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Determining the Differences of Racial Microaggressions Faced by Multiracial Versus Monoracial Minority Patients within Healthcare Settings

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DETERMINING THE DIFFERENCES OF RACIAL MICROAGGRESSIONS FACED BY MULTIRACIAL VERSUS MONORACIAL MINORITY PATIENTS WITHIN HEALTHCARE SETTINGS

by

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ABSTRACT

This study examines the disadvantages that multiracial patients face when seeking healthcare in the United States in comparison to the disadvantages encountered by monoracial minority patients. Specifically, this study mainly focuses on the impacts of racial microaggressions within such medical settings. This was explored using a critical discourse analysis, analyzing discourse presented from past research published from 2014 to 2023. Discourse was collected based on its relevancy to the given topic and was analyzed to identify general disadvantages presented for each subpopulation. It was found that multiracial patients face different disadvantages when receiving medical care in comparison to monoracial minority patients. The data collected within this study can be utilized to better understand not only the overall impact of racial microaggressions on the multiracial community, but to also expose how this issue manifests itself within a healthcare setting, as well as provide the opportunity to analyze the differences in experiences between monoracial minorities and multiracial minorities. This may provide further insight into how such issues can be better identified and addressed in the future as the multiracial population continues to grow.

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INTRODUCTION

Unlike absolute racial stereotyping, such as racial slurs or threatening statements, today's post-racial society has fallen towards the use of a more subtle form of racism: racial microaggressions. From a general perspective, racial microaggressions are defined as "brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages toward people of color" (CWSAC, 2019). Studies have confirmed that over time, these racial microaggressions can have a drastic effect on those who are subjected to them, particularly involving their psychological or physical health. There have been countless studies attempting to examine the effects and manifestations of racial microaggressions against minority populations, many focusing on the general/overall effect in day-to-day life or within a singularly specific aspect of life (Wong et al., 2014). Such examples focus on the lives of students, certain work environments (e.g. minority health professionals, engineers), and even in cartoons. This study aims to explore the impact of such racial microaggressions experienced by racial minorities seeking healthcare with a major distinction in that this study specifically considers the impact of racial microaggressions on multiracial individuals. A demographic often overlooked within the people of color grouping, multiracial individuals include those who identify with two or more races, often referred to as 'mixed racial' or 'biracial' (McGee, 2021).

With presenting the general forms of racial microaggressions that people of color experience, past studies have only focused on microaggressions experienced by monoracial individuals, which consists of those who identify/associate themselves with a singular racial or ethnic

category/background (Atkin et al., 2022). As a result of overlooking such individuals within research efforts, there is a possibility that these past studies have clustered multiracial individuals within their monoracial groupings. However, as researcher Jessica C. Harris explained in her study, for each particular circumstance the target population at hand may result in certain forms of microaggressions applied over those that may be applied against other demographics (CWSAC, 2019). This would mean that there is a potential for multiracial persons to experience entirely different forms of microaggressions compared to that of other people of color, and therefore should not warrant their placement within monoracial minority groups for academic studies. As one of the fastest-growing subpopulations in the United States, it is necessary to understand this unexplored impact of racial microaggressions on the multiracial community to better understand their influence on peoples' lives and therefore be able to reduce the number of incidences these people experience daily. This would include shifting the focus towards certain aspects of life such as experiences in the workplace, home life, or within this particular study, experiences seeking treatment in a clinical setting.

This study explores the impact of racial microaggressions on multiracial individuals seeking healthcare within the United States. However, the final piece that marks the originality of this study is not only the exploration of multiracial individuals' perspectives but that of monoracial minorities as well. This is because the differences in experiences with such microaggressions between multiracial populations and monoracial minorities have not been nearly as thoroughly investigated as other subpopulations, whether with or without involving the topic of seeking healthcare. Overall, this study examines the displayed sociological issue by asking, are patients who identify as multiracial subjected to facing a unique set of racial microaggressions compared to monoracial minority patients when seeking healthcare in the U.S?

The goal of this study is to highlight key differences between the impact of racial microaggressions on multiracial patients versus that of monoracial patients when seeking healthcare, and whether identifying as multiracial poses a unique set of disadvantages on such individuals within a healthcare setting. This study utilizes a critical discourse analysis approach in an attempt to answer the research question. A type of qualitative research method, this analysis will include the collection of various discourses from past studies that focused on either the multiracial or monoracial minority experience specifically from the perspective of a patient seeking healthcare, simply through the conduction of interviews. Each study collected aims to find overlapping/unifying experiences among participants' responses (McGee, 2021). The data collected within this study can be utilized to better understand not only the overall impact of racial microaggressions on the multiracial community but also to expose how this issue manifests itself within a healthcare setting, as well as provide the opportunity to analyze the differences in experiences between monoracial minorities and multiracial minorities. This may provide further insight into how such issues can be better identified and addressed in the future as the multiracial population continues to grow.

LITERATURE REVIEW

This section contains a review of the literature concerning a general outlook on racial microaggressions, monoracial and multiracial identity, the experiences of monoracial and multiracial persons both in day-to-day life and in medical institutions, and lastly an overview of patient-physician relationships with a particular emphasis on the minority patient perspective. It should be noted that all terminology and concepts described within the remaining sections of this study are based upon the historical and modern culture/social systems of the United States. It is also worth mentioning that this study particularly focuses on the experiences of diverse racial groups rather than on ethnicity. Ethnicity is defined as a type of shared culture, language, beliefs, values, and social norms of a group belonging to a shared place of origin. One of the main differences between race and ethnicity is that race is centered around the idea of power and privilege while ethnicity revolves around shared cultures, values, and beliefs (Atkin et al., 2022). This entails that racially focused studies analyze experiences of African American, Asian American, Native American, etc., rather than focusing on ethnic groups such as Latinx, Hispanic, etc., which are considered ethnic minorities. This review presents modern issues of the presence of racial microaggressions outside and within a healthcare setting, and how it can impact racial minority patients.

Racial Microaggressions: A General Perspective

A global description of the function of racism is that it aids in the conservation of social, economic, political, and ideological supremacy of one racial group. This results in a hierarchical type of society, where over time such racial categories are constructed to “serve specific needs”

(Atkin et al., 2022, p. 383). A significant example would be how "racial categories were used to justify the exploitation of Black slave labor in the United States" (Atkin et al., 2022, p. 383). Modern-day racism has transformed from the 'old fashioned' form, where racial hatred and bigotry were openly/publicly displayed, to a more subtle and concealed form that has become increasingly difficult to identify and acknowledge (Foster et al., 2014). This current form of racism, also known as racial microaggressions, can be defined as "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group" (Sue et al., 2007, p. 273). This type of racism is typically an unconscious act for which the offenders will often deny any prejudicial or malicious intent.

Over the past several decades, studies have identified a total of three distinct forms of racial microaggressions: microassault, microinsult, and microinvalidations. A microassault is the most blatant form, as it is an overt verbal or nonverbal attack intended to hurt the target. Examples of this form are racial slurs and are most like the 'old fashioned' type previously described. Microassaults are generally done with a conscious effort and are usually done under private circumstances (Sue et al., 2007). However, since the focus of this research paper is on the unconscious/unintentional forms of racial microaggressions, a greater emphasis on microinsults and microinvalidations will be in place.

It is also important to recognize that the degree of 'conscious awareness' may vary among individuals who commit these forms of microaggressions. Microinsults communicate one's insensitivity and disrespect towards an individual's racial heritage or culture. Difficult to detect, microinsults are usually subtle and can even come in the form of positive statements or compliments. For instance, when a hiring White employer tells a person of color "'I believe the

most qualified person should get the job, regardless of race' or when an employee of color is asked 'How did you get your job?'" (Sue et al., 2007, p. 274), the underlying message is that people of color are not qualified for the position or that these individuals must have attained the position through affirmative action or quota programs rather than through hard work and skill (Sue et al., 2007).

As described by Dr. Derald Wing Sue, a psychology and education professor at Columbia University, there are four categories of microinsults. The first is described as an *ascription of intelligence*. Here, minority racial groups often find themselves having been deemed with high or low intelligence. For example, Black or African American individuals are often regarded with a lesser intelligence while Asian Americans are often associated with being extremely bright, particularly in science and math. The second category is labeled as *second-class citizenship*, where individuals are treated as 'lesser' compared to other racial groups. This category feeds off the very definition of race/racism relating to the existence of a social/racial hierarchy. The third is known as *pathologizing values/communications*, where personal values or methods of communication of different racial groups are perceived as weird and abnormal. Lastly, the fourth category is known as the *assumption of criminal status*, where certain racial groups are presumed to be dangerous or perhaps associate themselves with criminal activity (Sue et al., 2007).

Microinvalidations are statements or behaviors aimed to nullify or deny the experiential reality faced by a person of color (Sue et al., 2007). One of the most common examples is 'colorblindness'. Here, the perpetrator will state that they 'do not see color' or that racial/cultural differences do not matter to them. While these statements may be spoken with good intentions, in turn, they negate the experiences of people of color (Foster et al., 2014).

There are four categories of microinvalidations. The first consists of *an alien in own land*. This category was formed based on the assumption that all racial minority citizens are foreigners, which is quite prevalent against Asian Americans. Questions such as "Where were you born?" or "You speak good English" insinuate that the individual is not from the current location and is automatically deemed as different (Sue et al., 2007, p. 74). The second category is known as *color blindness*, where individuals will deny the ability to 'see' race/color. As previously stated in the paragraph above, this indicates that the 'offender' fails to embrace the existence of differences in people and culture as well as negating the experience of people of color (Foster et al., 2014). The third category consists of *myth of meritocracy* which describes how an individual of color's success or failure in life is entirely due to one's own effort, ignoring the existence of external societal factors pitted against some races more than others. The fourth and last category of microinvalidations is known as the *denial of individual racism,* where an individual denies being part of perceived racism (Sue et al., 2007, p. 74).

Racial microaggressions can come from anyone, including health professionals. They "experience the same social conditioning as other human beings" and may inadvertently perpetrate microaggressions while with patients/clients who identify as part of these marginalized populations, including multiracial individuals (Foster et al., 2014, p.2).

Monoracial Minority Identity

The very definition of the term 'race' is then derived from the hierarchical organization of racial groups formed by racism, given the time and context of the society at hand. Historically within the United States, the formation of each racial group was and is largely based on phenotypic

traits such as skin color, hair texture, facial features, and eye shape, with its society favoring the supremacy of the White race (Atkin et al., 2022). Therefore, the concept of a minority race/identity is formed based on society's current definition of racism, based upon the established hierarchical formation of groups. Based on the options offered on the 2020 United States Census, a list of racial minorities includes: Black or African American, American Indian or Alaskan Native, Asian, and Native Hawaiian or other Pacific Islander. It should be noted that options for selecting or not selecting Hispanic or Latinx are presented in a different question regarding ethnicity (Jensen et al., 2021). This would then insinuate that a monoracial minority identity correlates with associating oneself with a singular racial group based on familial heritage and sociocultural, motivational, and cognitive factors (Atkin et al., 2022).

Racial Microaggressions: Day-to-day Experiences for Monoracial Persons

The concepts of race and racism surround the idea of a social hierarchy of racial groups, favoring the supremacy of one race over others. This results in continuous experience of various racial microaggressions, ranging from microassaults to microinvalidations and to microinsults. The subcategories for microinvalidations and microinsults listed above were written from a general perspective concerning all people of color. However, as stated in one study covering the daily racial microaggressions and ethnic identification experienced by young Native Americans, "there is both overlap and uniqueness to the discrimination experiences of different ethnic groups" (Jones & Galliher, 2015, p. 19). This indicates that different racial groups can experience the same or similar racial microaggressions listed above while also possibly experiencing some entirely exclusive to one race. Hence, it is then important to cover examples of specific racial

microaggressions of certain racial groups as well. This allows for better interpretations/analyses of described racial microaggressions depending on the racial group at hand.

It is important to note that references to everyday discrimination are deemed separate from major acts of discrimination such as housing discrimination, job firings due to race, or being denied a bank loan due to race. Rather, everyday acts of discrimination consist of those such as being "'treated with less respect,' 'perceived as dishonest,' 'threatened or harassed,' and 'called names'" (Keith et al., 2017). Across a span of multiple studies, many African Americans describe these situations as quite frustrating and stressful, leading to the overall conclusion that these experiences can have detrimental effects on one's physical and mental health (Keith et al., 2017). As described in the study previously mentioned, it has been demonstrated that many of these acts of discrimination were 'gendered' and 'classed'. In simpler terms, typically men and higher-educated individuals report experiencing these acts more often. It was also stated that different numbers of and intensity levels of occurrences vary amongst individuals partially due to the intersectionality of other social factors such as skin complexion and body weight. Specifically, African Americans report experiencing discrimination based on "two interlocking systems: their perceived membership in a racial group (racial discrimination) as well as, a phenotype-based continuum that privileges lighter skin tones and a more Eurotypical racial appearance over darker skin tones and a more Afrotypical racial appearance (i.e., colorism)" (Keith et al., 2017). Similarly, this study also reported that having a higher BMI has presented further social biases based on the cultural valorization of a thinner figure within the United States. Overall, everyday acts of racial discrimination for this racial group have been known to result in negative stereotypes (Keith et al., 2017).

Regarding the Native American minority population, one study stated many of their participants were found to associate themselves with both White and Native cultures, and nonetheless experienced discriminatory acts daily. A correlation was found between a higher identification with Native cultures in participants to a higher amount of racial microaggressions and other discriminatory acts experienced. It was found that many Native American individuals experienced both gender and ethnic bias as well (Jones & Galliher, 2015). Overall, some major variations of racial microaggressions are: *ascription of intelligence*, *myth of meritocracy*, *denial of individual racism*, and *assumed universality of Native experience*. Predominantly experienced by females, an *ascription of intelligence* conveys a message that Native Americans "are not expected to demonstrate aptitude, or are assumed to be less capable and less competent than Whites. Subtle messages that convey lowered expectations and dismiss the success of Native women have dramatic impact, as demonstrated by the large developing literature on stereotype threat" (Jones & Galliher, 2015, pg. 18). It is important to note the consistency between experienced racial microaggression themes between Native Americans and other people of color from a general standpoint. As formerly discussed within the General Overview of Racial Microaggressions section above, the themes of the *ascription of intelligence,* the *myth of meritocracy,* and the *denial of individual racism* all correlate to the themes also seen by Native Americans (and Black and African Americans). Native Americans also report being regarded as "lazy, untrustworthy, undeserving of assistance, primitive, prone to alcoholism, poor communicators uneducated and incapable, undeserving of a voice, and second class or invisible" (Jones & Galliher, 2015, p. 19). In reference to racial microaggressions in general, many racial minorities also report experiences of being considered untrustworthy as well as being second-class or invisible. This further supports the statement that there is indeed both an overlap and distinctiveness to such acts of discrimination,

as while similar acts are experienced across this racial group, the circumstances upon which these acts occur are still exclusive to each racial group.

A racial minority group that experiences racial microaggressions daily is Asian Americans. A study conducted by Dr. Derald Wing Sue and other colleagues investigated racial microaggressions by providing 10 self-identifying Asian American participants with a questionnaire. There were eight derived/identified 'major microaggressive themes': *alien in own land, ascription of intelligence, exoticization of Asian-American women, invalidation of interethnic differences, denial of racial reality, pathologizing cultural values/communication styles, second-class citizenship, invisibility,* and a *miscellaneous* category for minorly mentioned occurrences which require further research/exploration. It should be noted that many of these listed themes once again correlate with the racial microaggressions experienced by racial minorities in general such as: *alien in own land, ascription of intelligence, denial of racial reality, pathologizing cultural values/communication styles, second-class citizenship*, and *invisibility*. However, the study on Asian American experiences also clarified that nine out of ten of their participants were female, making these results largely gender specific. However, Sue also mentions that many other studies have also derived at least seven of the eight themes based on responses from a better gender-balanced pool of participants (Sue et al., 2007, p. 77).

As briefly mentioned in an earlier section, *alien in own land* relates to the assumption that all Asian Americans were foreign-born and therefore not 'real' Americans. Statements such as "where were you born?" or "you speak good English" are classic examples. The theme for *ascription of intelligence* is indicated when Asians are automatically 'assigned' a higher degree of intelligence based on their race. Participants in studies regarded their experience with this theme as causing

them to feel pressure to conform to such stereotypes, and that if they were not good academically it led to them feeling trapped. *Denial of racial reality* typically involves aggressors invalidating Asian American experiences with discrimination, claiming that there is no discrimination, inequalities do not exist, and that they 'have made it', particularly within statements such as "Asians are the new Whites". This therefore declines this racial group of incidents of racial bias and discrimination (Sue et al., 2007, p. 76). The fourth theme, *exoticization of Asian-American women,* consists of instances where Asian women are made to feel they are only needed to serve the physical needs of White men and nothing else. One Korean American participant from the referenced study stated that "she is frequently approached by white men who are very forthcoming with their 'Asian fetishes' of subservience and pleasing them sexually" (Sue et al., 2007, p. 76). *Invalidation of interethnic differences* is linked to the belief that all Asians look and are alike. One Filipino woman in this study provided an example stating, "I am always asked are you Chinese?". Another Chinese American participant referenced times where new acquaintances would often say phrases such as "Oh, my ex-girlfriend was Chinese, or my neighbor was Japanese" (Sue et al., 2007, p. 76). When asked how such statements made them feel, participants in this study believed that they implied that all Asian Americans are alike and that there are no differences between groups (such as Chinese versus Japanese), and that even if there was, it does not matter. The p*athologizing cultural values/communication styles* theme is known to convey the message that the cultural values and/or communication styles of other cultures besides that of the White and Western communities are less desirable and are wrong. A classic example against Asian cultures would be deeming that eating food with chopsticks rather than a fork or spoon is strange/weird. The seventh theme, *second-class citizenship* entails experiences that made it feel as though Asian Americans were lesser beings and/or second-class citizens compared to races higher on the

hierarchy. The last theme, *invisibility,* is like the third theme, *denial of racial reality,* where targets are often overlooked without the knowledge and direct intentions of the aggressor. For example, Asian Americans often find themselves being left out during racial discussions, which then conveys the message that Asians are not considered a minority, they "experience little to no discriminations and that their racial concerns are unimportant" (Sue et al., 2007, p. 78).

Multiracial Identity: How, What, Where, and Why?

After the legalization of interracial marriages in 1967, the multiracial minority population has since been deemed one of the fastest-growing racial/ethnic groups in the United States. In fact, in the 2000 Census, more than six million people had identified themselves with more than one racial group, and by 2050 it is projected that one in five U.S. citizens may identify as multiracial. Over time, this has led to increased advocacy for greater public recognition of the multiracial community and identity. Like all other races/ethnicities, there are several factors at play when attempting to define this minority group, which include theoretical, political, and social implications through racial category construction and racial identification (Shih & Sanchez, 2009).

Initially, racial category construction was centered around the idea that race was purely based upon singular and non-overlapping biological/physiological factors such as skin color (CWSAC, 2019). However, towards the 21st century, "the Institute of Medicine issued a statement that race is no longer a biological reality, and the use of race in biomedical, public health, and genetics research is usually considered to be a proxy for other social, environmental, and cultural experiences associated with racial categories" (Shih & Sanchez, 2009, p. 3). Today, racial categories are viewed to be constantly shifting parallel to current cultural and political climates.

To explain this concept, one study provided the example of how individuals of Irish descent were originally considered to be lower-class minorities but were later grouped with the general White race population as Black manual workers were considered the lower race in the mid-1800s. A more recent example of the political/social impact is that minority groups tended to encourage a broader ethnic inclusion within their racial categories rather than identifying 'multiracial' as their own group. This was done to prevent losing population count, which could have led to the loss of political power. These examples portray how easily this racial category can be influenced over time, the same as any other racial category. Therefore, the definition of 'multiracial' will forever be subject to change (Shih & Sanchez, 2009). Overall, a modern take on the term multiracial refers to individuals who identify with two or more racial heritages based upon the presently established racial criteria from social and political climates (Snyder et al., 2018).

One of the key aspects that separates multiracial classification from other racial categories is that it can be entirely based on one's self-definition/identity. As per the 2000 census being the first time in U.S. history where individuals were allowed to select more than one race, multiracial persons had the opportunity to identify themselves as they saw fit rather than having to select one option and choosing to identify with only part of themselves (Johnston & Nadal, 2010). While the influence of globalization and technological innovations have led to a more widespread acceptance of the concept of multiracial identity than in the past, studies have shown that these individuals continue to be 'pushed' towards associating with predetermined monoracial identities based on physical characteristics (Seto et al., 2022).

Multiracial Identity: Experiences and Positionality

Studies have found that the mutability of self-identity for multiracial persons largely varies with context (Seto et al., 2022), a concept also known as the ecological approach to the development of identity (Jackson, 2009). A study concluded that such contextual factors include *personal experiences of racism and discrimination, social interactions and relationships with peers and family, and the environmental racial climate of schools and communities* (Jackson, 2009).

Each of these factors was found to have both positive and negative effects on the development of each participant's identity. All participants from this study were able to recall an experience with racism. "These events usually launched participants into the cruel reality of racism and the idea that they were different because of how they looked and/or acted" (Jackson, 2009, p. 12), which then had a negative impact on each participant's own development of identity, particularly when such instances involved a close friend/peer. Participants recalled feeling like outcasts from those racially and culturally different than themselves (Jackson, 2009).

Participants felt that their families, specifically parents, posed a major positive influence on their racial and cultural identity as they introduced associated values, norms, beliefs, religion, art, and music. For example, one participant stated how "his mother's Korean background helped shape his value of respect, while his father's Italian background led him to become an outspoken person who strongly believes that "blood is thicker than water" (Jackson, 2009, p. 12). However, participants also described a few negative aspects of this factor regarding parental behavior. Common instances include avoiding discussions concerning racial and ethnic issues, and directly or indirectly discriminating against participants' physical appearance. As a result of these parental

behaviors, participants described feeling “confused, ashamed of their appearance, and disconnected from both their parent(s) and/or a prominent piece of their culture” (Jackson, 2009, p. 13).

Lastly, *environmental context*, plays a large impact on the cultural identity of multiracial individuals. Studies have shown that the racial and cultural composition of communities affected the levels of exposure that this population has to self-identifying experiences, both positive and negative (Jackson, 2009). Schools are one of the most significant places where such individuals develop an increased awareness of what makes them ‘stand out’. From daily interactions with classmates to institutional forms that only allow for the selection of one race, multiracial students are exposed to eye-opening events. However, once these individuals entered college, many stated they then had more opportunities to better explore their cultural identities and who they are (Jackson, 2009).

As illustrated, it can be stated that the development of multiracial individuals’ identities varies from person to person. It is entirely based upon the unique upbringing, lifestyle, and community that these individuals are exposed to (Seto et al., 2022). There are five potential identities that these individuals choose to associate themselves with: monoracial identity (selecting only one racial category), multiple monoracial identities (selecting multiple racial backgrounds), multiracial identity (selecting a term that indicates a multiracial identity such as ‘biracial’ or ‘mixed’), extraracial identity (choosing not to associate with any racial category), and situational identity (selecting a racial category based on the circumstances at hand) (Johnston & Nadal, 2010).

Racial Microaggressions: Day-to-day Experiences for Multiracial Persons

Pertaining to the multiracial community, a common term utilized to describe acts of racism against this subpopulation is known as monoracism. This term is defined as "systemic social oppression that targets individuals who do not fit into monoracial categories, groups, or phenomena" (Johnston-Guerrero et al., 2020, p. 18). In branching to general acts of racial microaggressions, five common forms of racial microaggressions have been identified as being frequently experienced by multiracial individuals on a day-to-day basis. These forms are listed as: *exclusion and isolation, exoticization and objectification, assumption of monoracial identity, denial of multiracial reality, and pathologizing of multiracial identity and experiences* (Foster et al., 2014). As demonstrated in previous sections, it should be noted that there is both a continuous overlap and distinctions among these discriminatory themes because every racial group has different experiences under diverse circumstances, and the multiracial community is no exception.

The first form of microaggression, *exclusion and isolation*, occurs when multiracial individuals are made to feel excluded/isolated because of their multiracial identity (Johnston & Nadal, 2010). Within this form of microaggression, several subthemes have been recognized: questioning of authenticity, endorsement of monoracial society norms, and discriminating treatment towards multiracial persons. The first subtheme involves these individuals made to feel different or inferior because they do not 'fit in' with the monoracial crowd. Quotes such as 'You aren't (insert race) enough' are classic examples. The second subtheme is typically found on demographic forms as many do not allow for more than one race to be selected. This almost 'forces' participants to select only one part of themselves to identify with, which is considered an unconscious advocacy for a completely monoracial society. The last subtheme includes instances where monoracial persons are slow to warm up towards accepting multiracial peers, almost treating them with a 'second

class-like' status. This communicates that these individuals are different and do not entirely belong to monoracial groups, especially in situations that call for individuals to be fully proficient in a specific culture (CWSAC, 2019; Foster et al., 2014; Johnston & Nadal, 2010).

Exoticization and objectification occur when these individuals are made to feel dehumanized/objectified. As stated in one study, "the ubiquitous experience of being asked 'what are you?' is a prime example of potentially making multiracial persons feel dehumanized and abnormal, with a person's phenotype usually playing a significant role in these types of microaggressions" (Johnston & Nadal, 2010, p. 13). This second type also encompasses multiple subcategories such as publicizing racial identities, sexualized objectification, and being viewed as the prime example of a post-racial society. The first subcategory refers to situations where other individuals "feel entitled to ask multiracial people questions about their background that would not normally be asked of non-multiracial people" (Johnston & Nadal, 2010, p. 13), which is considered an invasion of privacy and creates feelings of discomfort. The second subcategory involves being objectified in a sexual matter. Statements that describe these individuals as 'exotic', particularly for women, convey the message that only physical appearances are valued. Like the second subcategory, the third form involves these individuals depicted as the "racialized ideal" (Johnston & Nadal, 2010, p. 13). Statements such as 'you have the best of both worlds' or 'everyone will be multiracial one day' objectifies multiracial individuals from a different social perspective (CWSAC, 2019; Foster et al., 2014; Johnston & Nadal, 2010).

The third form of racial microaggression, *assumption of monoracial identity*, occurs when automatic assumptions of monoracism are made based on appearances or last names. Other such examples occur when people make assumptions about familial relationships, or rather the nonexistence of them. Multiple individuals from studies remarked that many people will

automatically assume that the parents of multiracial children are not related to them and are presumed to be nannies or adoptive parents. These instances portray the message that multiracial individuals must have the same appearance as their family members to be of the same race (CWSAC, 2019; Johnston & Nadal, 2010).

Denial of multiracial reality typically occurs when multiracial individuals are unable to choose/select the races they identify with. This form differs from form three in that the aggressor has prior knowledge of the individual's racial background but proceeds to associate them solely with one race. Being placed into a situation where peers and strangers constantly "claim" these individuals to a certain racial group unknowingly gives the community the power to determine one's identity rather than the individual deciding for themselves, and that their behaviors should reflect the communities' chosen race (CWSAC, 2019; Foster et al., 2014; Johnston & Nadal, 2010).

The fifth and final general form of racial microaggressions is known as the *pathologizing of multiracial identity and experiences*. Being like forms one and two, this form involves multiracial experiences/identities deemed to be entirely different from the norm or even psychologically abnormal. This also has a similar effect of leaving these individuals feeling isolated and excluded due to these differences, as they are "living in-between two distinct peoples (races) but never being fully accepted by either group" (Johnston & Nadal, 2010, p. 15).

Link to Medical Institutions: Physician-Patient Relationships

Racial microaggressions can occur at any time between any set of individuals, and the medical field is no exception. However, before discussing the specific variations of racial microaggressions within healthcare settings, it is important to understand the relationship behind them and how/why they can occur i.e. "the doctor–patient relationship has been and remains a keystone of care: the

medium in which data are gathered, diagnoses and plans are made, compliance is accomplished, and healing, patient activation, and support are provided" (Dorr & Lipkin, 1999, p. 26). In an analysis of a typical encounter between a physician and a patient, there are a total of three interrelating functions and fourteen structural elements. These functions consist of: *gathering information to determine the nature of the problem at hand, developing/maintaining therapeutic relationships, and communicating/educating information to the patient.* The structural elements consist of: *properly preparing the environment, preparing oneself for interactions, observing the patient, greeting the patient, beginning the interview/encounter, properly identifying and surpassing potential barriers to communication, surveying issues, negotiating priorities, "developing a narrative thread, establishing the life context of the patient, establishing a safety net, present findings and options, negotiate plans, [and] close the interview"* (Dorr & Lipkin, 1999, p. 26). The purpose of attempting to understand the functional and structural components of physician-patient interactions is to foster a positive and mutually trusting connection. For example, if a patient were to feel negatively towards their physician, the initial mistrust of the relationship may result in them not as forthcoming with health-related information, preventing the physician from providing a thorough level of care. Therefore, the status of the relationship between physician and patient is necessary to ensure the highest quality of care can be provided (Dorr & Lipkin, 1999).

It is also important to discuss the power dynamic of a physician-patient relationship, as well as the influences of societal and cultural structures/processes on their communication (Crosley, 2021; Wall et al., 2025). Within this relationship, patient backgrounds may affect providers' perception of normalized power, therefore impacting their communication of information or vice versa. Such background factors include socioeconomic status, occupation, education level, gender,

ethnicity, and - most relevant to this study - race (Jones et al., 2020). For example, if a patient is uncooperative with treatment advice, this could lead the physician/provider to become frustrated "without acknowledging contextual stressors…thus the patient may feel less supported and fail to follow-up on recommended treatments" (Cruz et al., 2019, p. 3). This cycle of upsetting microaggressions and mistrust/lack of communication within this relationship warrants the need for further exploration within this field to help improve such relationships.

It is also important to recognize the manner in which patients are recognized by race, ethnicity, monoracial, and/or multiracial in healthcare encounters. Specifically, the three most commonly used methods of attaining such patient information occurs through "direct observation, indirect estimation using geocoding or surname recognition, and self-report" (Wittmer et al., 2023). The first method, which involves appearance-based assumptions of perceived identity, has shown significant patterns of inaccuracy in terms of assigned race and/or ethnicity (Wittmer et al., 2023). This could potentially lead to medical records being documented with the incorrect race (Snyder et al., 2018). Similarly, the second method has also been remarked as notably inaccurate in certain instances. Actions of estimating/guessing geographic place of origin or last name/surname recognition have also been deemed with potential inaccuracy. Errors from the utilization of the second method are typically seen amongst Black or African American, American Indian, Alaska Native, and multiracial or multiethnic individuals. Lastly, the third method of patients self-reporting their race and ethnicity based upon their own self-identity is considered to be the most accurate and respectful approach to proper documentation (Wittmer et al., 2023).

Lastly, it is also equally crucial to discuss the reasoning as to why studying such social issues in healthcare is important, and why this study is relevant to this subject. As previously mentioned, race is no longer considered a biological reality (Shih & Sanchez, 2009, p. 3), yet it was and still

is used to justify the oppression of people of color. Specifically, “in one survey of 600 US physicians in 2005, 81% believed that race should be used as a biological variable to determine disease and 85% felt that drugs for specific racial and/or ethnic groups provide a therapeutic advantage” (Mateo & Williams, 2021, p. 1). These results further illustrate how healthcare staff may tend to primarily associate race with biological differences rather than associating it with social categorization, which may lead to differential care. Furthermore, experiencing racism in both day-to-day life as well as when seeking healthcare can result in exposure to a wide variety of psychosocial, economic, and environmental stressors. Consequentially, this may further lead to earlier onset, increased frequency, and increased severity of disease. This issue therefore demonstrates the dire need to study and understand the experiences of different minority groups in regard to racial disparities in health and/or healthcare. Once more information on such processes is better understood, the next step must be to educate the healthcare community “that addressing racism is at the core of addressing racial disparities in healthcare. Thoughtful training to address racism in healthcare, reduce biases, and increase patient centered care should be integrated throughout the healthcare community and provided to all members, regardless of training level” (Mateo & Williams, 2021, p. 2)

Racial Microaggressions in Medical Institutions: Monoracial Minority Experiences

After several decades of research, there is much evidence supporting the fact that racial minorities experience lower levels of communication and negatively explicit attitudes from physicians. The Institute of Medicine reported that “disparities in healthcare emerge from bias [or prejudice] against minorities; greater clinical uncertainty when interacting with minority patients; and beliefs [or stereotypes] held by the provider about the behavior or health of minorities”

(Cooper et al., 2012, p. 979). As previously described, racial microaggressions (namely microinsults and microinvalidations) do not regularly involve overt malice, or specifically regarding healthcare settings, clear negligence from healthcare staff. Most reports of racial microaggressions within healthcare settings describe subtle actions and exchanges where patients felt that their needs were ignored or that they were insulted/disrespected. Examples include only being addressed by first name, receiving unsanitary or secondhand medical treatment, and facing automatic assumptions of being ignorant, poor, or primitive (Ross et al., 2012). One study that analyzed the negatively explicit attitudes experienced by both Black and White patients consistently found that Black patients received poorer ratings of patient care, which ultimately led to less patient-centered dialogue, increased patient mistrust, and less patient confidence in their physician. This then resulted in an increased number of relatively unhealthy physician-patient relationships. The study also claimed that previous research "[reflected] more racial bias predicted less speaking time, less smiling, fewer social comments, less speech fluency, and more speech errors among participants interacting with Black (than White) experimenters" (Cooper et al., 2012, p. 983). One of the major takeaways from this is that these instances described are consistent with many of the general microaggressions faced by racial minorities in everyday life (Ross et al., 2012). From an opposing perspective, many studies have also found that physician behaviors that minority patients identify as microaggressions were made with well-intentioned efforts to not seem prejudiced (Cooper et al., 2012). Despite many of these occurrences being inadvertent, contemporary models of such situations claim that this characterizes an 'institutional betrayal', "which reflects the systematic organizational practices that fail to respond to discrimination and microaggressions appropriately" (Cruz et al., 2019, p. 2). Regardless of the intentions from either side of this relationship, it is important to be aware of the specific characteristics of each

circumstance to avoid discriminatory interactions, specifically regarding proper identification of the patients' racial background.

Racial Microaggressions: Branch to Medical Institutions and Multiracial Reality

While studies have shown that multiracial individuals experience some of the same forms of general microaggressions in a healthcare setting, they also found several differences in their overall impact on patients. For instance, a study illustrating how racial microaggressions can manifest for multiracial patients and their families stated that one of the key differences between the two is the shift in the power dynamic between patients and providers (Snyder et al., 2018). The authors further elaborate on this statement by stating, "Unlike everyday experiences of microaggressions in which one might ignore of disregard a stranger's comment of question, in the context of seeking healthcare, patients were uncertain as to what questions they felt they needed to supply to guide their healthcare decision making versus what they were being asked to satisfy a provider's curiosity" (Snyder et al., 2018, p. 236). The authors then commented on how the combination of general racial microaggressions with this shift in the patient-provider power dynamic further contributes to the complexity of the impact they have on multiracial patients from a psychological and physical perspective (Snyder et al., 2018).

As previously stated, studies have found overlap among general daily racial microaggressions with those experienced when seeking healthcare. However, it is still equally important to elaborate upon these specific healthcare-related experiences and both the similarities and differences in the impact that they have on multiracial patients versus that of other racial or ethnic groups.

Racial Microaggressions in Medical Institutions: Multiracial Experiences

Based on the findings of multiple studies, there are six forms of racial microaggressions that multiracial patients experience within the healthcare system. These forms are listed as: *mistaken identity, mistaken relationships, fixed forms, pervasive stereotypes, intersectionality,* and *entitled examiner.*

The first form of healthcare racial microaggressions is known as *mistaken identity*. Like the third general form of racial microaggressions discussed previously, this form typically occurs when healthcare providers or staff make an automatic assumption of the patients' race, usually presuming they are monoracial. Respondents from one study reported that as a result there have been multiple instances where medical records were documented with the incorrect race. One respondent recalled a time when she had gone to take an HIV AIDS test. In this instance, her provider had shown her the paperwork that gave negative results. However, the patient had noticed that the form identified her as a 'white female'. Since the patient did not identify as white, she was extremely confused and assumed the form was not meant for her. She had then left the meeting wondering if she may be HIV positive after all (Snyder et al., 2018). Examples such as this demonstrate how simply presuming one's race can have a drastic impact on patients' lives.

The second healthcare form of racial microaggressions is known as *mistaken relationships*. Here, automatic assumptions are also made based on appearances and last names. In one study, many of the respondents described times when they were with family members at a health clinic or hospital where staff members assumed they were not related. For instance, "one participant recalled their experience when accompanied by their parent: 'I remember the discomfort that my dad, when he would take me into the doctor when I was younger, that they'd [clinic staff] be like, 'Oh, is this your new adopted child? What's your relationship to this child?' And it's such an

awkward moment for him and myself." (Snyder et al., 2018, p. 233). Situations such as these create awkward and uncomfortable moments for the patients and their families, while also inadvertently conveying that all family members should look like one another and that when they do not then it should be assumed that they are unrelated.

Comparable to the general fourth form of racial microaggressions, the third form of healthcare-related microaggressions is known as '*fixed forms'*. While many modern-day medical forms have been updated to allow more than one race category to be selected, some have not. In one study participants claimed that if selecting more than one category is unavailable, they would prefer to be able to select a 'multiracial' category rather than having to select only one of the races that they identify with (Snyder et al., 2018).

The fourth form is known as *pervasive stereotypes*. Like the microaggressions that many monoracial people of color experience, many multiracial patients are also subjected to racial-stereotype-based presumptions about their education, insurance, or financial status by healthcare staff. Many participants from a study recalled how easily the communication style between patient and staff interactions would change based on provider awareness of the patients' qualities/background. For instance, one respondent stated, "I think I've had numerous times, and I don't know if this is race or age or what, but numerous times people are all of a sudden, 'Oh, you have a Ph.D.?' and then, all of a sudden, they feel like they can talk to me in a completely different way about what's going on with me even" (Snyder et al., 2018, p. 234). Other factors that participants felt impacted communication styles included the clothing they wore, leading them to dress in a certain manner to receive certain levels of attention in care (Snyder et al., 2018).

The fifth form of healthcare racial microaggressions is *titled intersectionality*. Like the fifth general form of racial microaggressions, the title of this category is linked to the difficulty of

attempting to distinguish one form from another. As described by one Native American-Latino respondent, “I guess it’s just one of those things that it’s hard for me to necessarily pull out what is race-related and what isn’t” (Snyder et al., 2018, p. 234). As referenced by several participants, most intersections include gender, age, race, citizenship, disability, language, etc. (Snyder et al., 2018).

The sixth and final form of healthcare racial microaggressions is known as *entitled examiner*. This form of healthcare racial microaggression can be considered a key example of a change in the power dynamic when it comes to patient-doctor interactions and encompasses all other forms of the healthcare microaggressions discussed. While multiracial persons can easily dismiss the typical day-to-day racial microaggressions, it becomes much harder to distinguish which questions should be considered necessary for medically related information or if they should be deemed as socially inappropriate, biased questions that invade patients’ privacy. These probing questions can be entirely based upon assumptions based on appearance, expectations on racial background/education, gender, sexuality, etc. In one study many patients stated that they believed their providers’ questions were well-intentioned, resulting in them learning over time to expect similar questions whenever seeking healthcare in the future. It should also be noted that this form of healthcare racial microaggression is also commonly experienced by monoracial people of color as well (Snyder et al., 2018).

Link to Current Study

Based on previous research findings, it can be claimed that the forms of racial microaggressions that the multiracial population experience differ from those faced by monoracial people of color. However, these differences may vary based on different contexts or circumstances,

specifically in healthcare settings. Once again, the purpose of this study is to determine whether multiracial patients face a unique set of disadvantages in comparison to monoracial people of color in terms of experienced racial microaggressions. The study aimed to uncover if multiracial patients are subjected to facing different racial microaggressions than monoracial minority patients when seeking healthcare in the U.S. As displayed within the previous sections of this review, it has been found that "there is both overlap and uniqueness to the discrimination experiences of different ethnic groups" (Jones & Galliher, 2015, pg. 19). In relation to the current study, this would then indicate that the multiracial demographic could also potentially experience the same or similar racial microaggressions previously listed while also possibly experiencing some that are entirely exclusive.

METHODS

Current Study: Purpose, Background, and Method of Approach

This study examines the differences in disadvantages that multiracial patients face when seeking healthcare in the United States in comparison to the disadvantages encountered by monoracial minority patients in terms of experienced racial microaggressions. Specifically, this study mainly focuses on the impacts of racial microaggressions within such medical settings. A critical discourse analysis was utilized to collect discourse, or written communication, for this qualitative study that was published between 2014 and 2023 (Cambridge Dictionary, 2019). The collection of discourse, research, and further analysis was conducted from August 2023 to November 2023, as well as a continuous development of the literature review as more information was disclosed. Discourse was collected based on its relevancy to the given topic and was analyzed to identify general disadvantages presented for each subpopulation. The data collected within this study can be utilized to better understand not only the overall differences of racial microaggressions in the multiracial community but also to expose how this issue manifests itself within a healthcare setting, as well as provide the opportunity to analyze the differences in experiences between monoracial minorities and multiracial minorities. This may provide further insight into how such issues can be better identified and addressed in the future as the multiracial population continues to grow in the United States.

Discourse Selection: Strategy and Criteria

This study was conducted at the University of Central Florida (UCF), the UCF Library Database was largely relied upon to find and select the discourse used. The database permitted free

access to studies found on academically focused search engines such as Google Scholar, Research Gate, Pew Research, and PubMed. Once again, the search for this discourse was conducted from August 2023 through November 2023 and was determined to be completed once a saturation point was reached.

The criterion for selected discourse includes the following: the educational background of authors, the overall goal of the research, the time the study was conducted/published, and the type of data collection used. For this study, each source's author(s) was reviewed to ensure that they have an educational background in medical sociology or a related subject. The selected discourse was reviewed to ensure that the author(s)' overall goal was to identify general themes of such racial microaggressions for either monoracial or multiracial persons, specifically within a healthcare setting in the United States. Before proper selection, each discourse entry was confirmed to have been released between the years 2014 to 2023. Lastly, studies were determined to have fully met the criteria based on whether they used interviews or focus groups to answer their research questions to ensure that findings were collected/determined directly from those afflicted by such social inequalities. The utilization of this method confirms that the findings presented within each discourse piece are relevant to the issues at hand and appropriately consider the perspective of these minority individuals from a patient viewpoint.

In pursuit of the discourse, many different 'phrases' were explored based on whether studies focusing on the multiracial or monoracial perspective were needed. To find the discourse investigating the multiracial perspective, the following phrases were searched: *multiracial patient experiences with racial microaggressions, multiracial experiences with racial microaggressions in health, racial microaggressions against multiracials in health,* and *multiracial experiences with*

racial microaggressions within clinical settings. To find the discourse discussing the monoracial minority perspective, the following phrases were searched: *racial microaggressions in healthcare, patient experiences with racial microaggressions in healthcare, patient experiences with racial microaggressions in health, (insert race) patient experiences with racial microaggressions in health,* and *experiences with racial microaggressions within a clinical setting*. It should also be noted that once a discourse piece was identified to have successfully met the criteria, the provided references used within that piece were then examined to find other potential discourse to be used in this study using the same criteria.

A total of eleven items of discourse were determined to have met the listed criteria, with six falling under the monoracial minority perspective and five falling under the multiracial minority perspective.

Procedure

Upon proper selection of discourse based on the criteria listed above, a critical discourse analysis was used to evaluate each piece. The first portion of this procedure involved a search for keywords, consistencies, and contradictories within basic elements of the results of each discourse such as vocabulary, grammar, sentence structure, text organization, culture, and intertextuality (Nicolas, 2021). An analysis of vocabulary, grammar, and sentence structure was used to examine the meaning of words/phrases concerning the context of the discourse. This included the passive/active wordings used in conducted interviews/focus groups, the types of questions asked of participants, and the concluding statements and perspectives of the writers themselves. Lastly,

the analysis of intertextuality involved investigating the influences of other literature on the text at hand, and their significance to the piece.

The second portion of this procedure included the analysis of other aspects of the discourse such as the overall context, argument composition/structure, the authors' discursive statements, and any literary figures present. Such aspects/elements of the discourse were then used to formulate codes, which then allowed for the proper identification of various themes and patterns. These identified themes were then given descriptions and confirmed by reevaluating the discourse. Depending on the context of whether the piece was oriented towards the experiences of monoracial minorities or multiracial individuals, the themes/patterns uncovered were then evaluated to determine what general underlining disadvantages are present. It should also be noted that once the themes were formed, each code was reevaluated to ensure they were examined both thoroughly and efficiently.

Overall, with this procedure, the similarities and differences between the thematic trends gathered from studies that met the criteria were recognized. Any trends that appeared to have common ground between the two separate discourse pools (multiracial versus monoracial minority) were identified and further explored through analyses to determine why and how they occur within their circumstances. The results were then used to determine any key differences between racial microaggressions experienced by monoracial minorities versus those of multiracial minorities when seeking healthcare in the United States and also to identify the similarities present as well. This procedure was used to address and answer the proposed research question. An analysis of the results will be further elaborated upon in the following discussion section.

RESULTS

Overview

As demonstrated by the previous methods section, a critical discourse analysis was performed to generate overarching themes that best depict the disadvantages experienced by either monoracial minorities or multiracial individuals. This allowed for further comparisons and contrasts to be made between them, which will be further elaborated upon within the discussion section below. The results of this study are portrayed within two main subsections, with the main parting factor being whether the perspectives/experiences of either monoracial minority or multiracial individuals were considered. The first section, *Monoracial Themes*, includes a group of six main themes/topics of general disadvantages faced by monoracial minorities that were consistently presented throughout the selected discourse. Similarly, the second section, *Multiracial Themes*, includes a group of seven main themes/topics of general disadvantages faced by multiracial individuals that were consistently presented throughout the selected discourse as well. It should be noted that the designated distinction between identified themes was based on the discretion of the researcher and what they deemed was most appropriate to best cover all presented topics at hand.

Monoracial Themes

Facing Dismissive Attitudes from Staff

In a large portion of the selected discourse, patients commonly referenced experiencing dismissive attitudes and behaviors from healthcare staff when discussing any perceived racism or discrimination. Facing such behaviors resulted in patients feeling as if they were not being heard and that their health challenges should be disregarded. For example, a patient from a study on

orthopedic patients referenced an experience where she had to repeatedly ask her physical therapist to educate her on whether she was performing treatment exercises correctly. This left her feeling as if "her orthopedic needs were minimized and disregarded" (Bond, 2022, p. 30). Another participant recalled feeling as if her physical therapist had also been dismissive and disregarded her needs, taking note of how many of the instances were quite subtle. She stated, "That's not okay." Because now you're, you're trying to talk to me as if I don't know my own body, as if I don't know my own medical history, as if I'm not paying attention to the last 30 years of my life...It's subtle. It wasn't anything overtly racist or misogynist, right? It's the subtle stuff" (Bond, 2022, p. 30). Another study focusing on patient perceptions of discrimination and satisfaction showed that many of their participants also had similar experiences where facing such dismissive attitudes served as nonverbal cues of disrespect by staff members (Tajeu et al., 2015). Additionally, one other study that analyzed patients' perceptions of microaggressions and discrimination while treated in the emergency department briefly mentioned the presence of dismissive communication in a list of negative staff behaviors (Punches et al., 2023)

Another study that aimed to highlight patient experiences with racial microaggressions in therapy incorporated several instances of dismissive behaviors from clinical staff. One of the major associated themes listed in this study was patients' negative experiences, particularly concerning staff's dismissiveness about race. For example, one Black participant referenced multiple occurrences where her therapist consistently disregarded her concerns about experiencing discrimination in the workplace. She stated that "whenever [she] would mention that to [her] therapist,…he would be dismissive, " 'Why would you say that?'…It would never be,… 'Oh, please elaborate.'…He was just…dismissive" (Okosi, 2018, p. 79). In another instance, the same

participant recalled another dismissive occurrence with the same therapist. “his response just seemed like he didn’t believe me.…He was…asking questions like…, ‘Well why do you think that?’… ‘Well what happened?’…‘Do you know exactly what they went through?’… And it was…really dismissive. It was…like he wasn’t even listening to what I was saying” (Okosi, 2018, p. 95). Another Black participant recalled a similar instance with her therapist in which she stated that having to withstand such dismissive attitudes/statements “didn’t inspire her to stay” (Okosi, 2018, p. 108). This example showcases that having to withstand dismissive attitudes from clinical staff can drastically impact patients to the extent that they terminate treatment. One last example includes the comments of a South Asian female participant on facing such attitudes: “having only a superficial knowledge of other cultures can be harmful and dismissive to patients who can benefit from effective, culturally informed therapy” (Okosi, 2018, p. 139). As each example demonstrates, facing dismissive attitudes is heavily regarded as a negative experience/disadvantage that patients commonly face, and may insinuate that such interactions are unwanted and/or inappropriate for discussion. However, the presence of this theme insinuates a much larger underlying issue. Specifically, Okosi explains that these attitudes may be derived from implicit biases or negative feelings about race, resulting in an unconscious avoidance of related topics. She further states that such consistent dismissiveness/minimization may “have been driven by the common desire to preserve their self-concept as good, moral people; however, the underlying cognitive dissonance caused blind spots resulting in clinicians’ inability to recognize the occurrence of a microaggression” (Okosi, 2018, p. 152).

Facing Negative Attitudes/Behaviors from Staff

This theme includes both conscious and unconscious behaviors of healthcare staff members identified by patients throughout the selected discourse. While all racial microaggressions are unconscious acts of racial discrimination, there is a separate distinction between unconscious and conscious communication (Sue et al., 2007, p. 273). Conscious (verbal) communication relates to moments when the speaker actively thinks about the message they are trying to convey. In contrast, unconscious (nonverbal) communication relates to nonverbal cues in relation to one another and the overall context of the scenario at hand, which may not always be explicitly thought out (Pressbooks by University of Minnesota Libraries Publishing, 2013). Selected discourse referenced several incidences where patients identified such potential communications.

For example, a study that analyzed domains of dissatisfaction associated with racial/ethnic discrimination among patients with pain quoted several participants with similar experiences of facing such negative attitudes. With one of the most frequently identified themes being *uninformative staff*, one African American patient recalled an experience where employees suddenly stopped giving her treatment injections. She stated "they never told me why they quit giving me the injections, they never explained to me why they stopped. . . One day I went to the clinic and there was a new fellow there, and he said that he couldn't give me the injections and that they couldn't give them to me, and it was over- that was gist of the explanation to me" (Hausmann et al., 2020, p. 12). Another common code within this study, *employees were unconcerned or uncaring*, was identified and elaborated upon using an instance described by another African American participant. He stated, "you are treated like waste. The level of treatment that you receive from those people that you have to sit back and deal with that are not sensitive to your needs because they have no idea what is going on with you" (Hausmann et al., 2020, p. 12).

A study that analyzed patients' perceptions of microaggressions and discrimination while treated in the emergency department briefly mentioned the presence of rudeness and unprofessionalism in a list of negative staff behaviors (Punches et al., 2023). Additionally, a study on orthopedic patients listed how one participant felt as if staff were nonchalant and unenthusiastic in regards to treatment and treatment goals. They stated, "In physical therapy...they ask you [if you have] a [treatment] goal. You know, what is your goal? Even if it's really not realistic, you still have a goal. And I remember asking one person, I say, " 'You didn't ask me what my goal was.' She said, 'Oh. What is your goal?' And I told them my goal and they said, 'Oh.' And...as if I couldn't have one... that was pretty much it and I believe she wrote something down at that time, and that was it. That was it... it was nonchalant. It was...you know, 'Are you serious?' You know, 'Are you for real?' You know, you know, Look at you" (Bond, 2022).

Lastly, the formation of this theme was also derived from a study focusing on patient perceptions of discrimination and satisfaction where participants discussed issues with both staff members' verbal and nonverbal communication. Under verbal communication, a brief description was listed where staff members presented a negative tone of voice or shortened responses. Regarding nonverbal communication, participants had taken note of a lack of staff smiling or other positive facial expressions, which was taken as a sign of disrespect. The study also stated that several participants noted a frequent lack of attention and eye contact by staff (Tajeu et al., 2015, p. 2079). Overall, in facing these negative attitudes from staff, patients are not only put at a disadvantage in receiving proper care but also further subjects the patient-provider relationship to even more stress.

Facing Racial/Cultural Stereotypes from Staff

This theme largely focuses on typical racial microaggressions experienced by monoracial minorities within clinical settings. In addition to the lower levels of communication and negatively explicit attitudes described in the other identified themes, a large number of patients throughout the selected discourse had experiences where they faced unconscious racial and cultural stereotypes from clinical staff.

In a study that analyzed the prevalence and correlates of racial microaggressions experienced by American Indian adults with type 2 diabetes mellitus, 21.8% of respondents endorsed the statement that "my health care provider sometimes seemed to have stereotypes about my cultural group, even if he or she did not express them directly" (Walls et al., 2015, p. 234). In another study that aimed to identify themes of patient dissatisfaction associated with perceived racial/ethnic discrimination among patients with pain, the authors stated that feeling stigmatized was a frequent code (Hausmann, 2020).

A study that analyzed patients' perceptions of microaggressions and discrimination while treated in the emergency department included a qualitative analysis of differential treatment by clinical staff. One of the major resulting themes labeled as *Perceived Reasons for Discrimination* included several participant statements regarding their experiences. For example, one female Black participant stated "People have different situations and different things that's going on when they have to come into the ER and might look a certain way, maybe unclean or unkempt. It doesn't mean that they're always like that" (Punches et al., 2023, p. 1197) in response to experiencing appearance-based pervasive stereotypes. Similarly, another Black participant commented on the ways patients of different races are spoken to by staff. They stated, "I don't need [them] talking to

me like that … If you was sitting out in that waiting room, and just analyze, analyze how they talk to Black people, how they talk to foreigners, how they talk to White people, then you'll see it for yourself" (Punches et al., 2023, p. 1197).

In another study examining the experiences of minority orthopedic patients, authors listed the comments made by one respondent recalling interactions with her provider concerning treatment compliance. She stated, "If I did [the] exercise that...was given to me and...it was improvement, it was like, 'Really?' You know, like, 'Really? You actually did these exercises?' You know, 'cause it was like, it was... [an] amazement type of thing. [The therapist was] surprised... more surprised than anything. And ...that was, I mean, that was more racial...as well as...looking at...my body, you know" (Bond, 2022, p. 31). In reflection of this interaction, the respondent marked how they felt as if they were judged by their appearance in terms of their weight and race, and that the therapist immediately had low expectations of them because of this. This was marked under unconscious discrimination as the incident was more subtle and appeared to be directed at someone who appeared to fall within a general identity (Bond, 2022).

Unfortunately, this study also marked several respondents' statements as incidents of conscious discrimination that were based on erroneous assumptions, which most likely led to such poor-quality care. Specifically, the study demonstrated that results indicated that providers' assumptions may have led to patients being taken for granted, assuming that providing lower-quality care still met an acceptable criterion. One participant described an incident where they had to repeatedly ask their physical therapist to properly measure their legs after receiving a hip replacement but was consistently dismissed. He stated, "Dr. J, he was my [orthopedic] surgeon for my hip...I went back to see him several times after my surgery complaining of pain...I would always ask him to give me

the exact length of my right hip which he would never do. I asked him several times, and it wasn't until I went for a second opinion up at Facility B... when I really found out the true measurement. He [Dr. J] would always say off the top of his head that it was 3/8ths [of an inch]. He said "I think it was just about 3/8ths" instead of really properly measuring it, like I was to accept that. And looking back on it, the way he did it I kinda think that he was taking me for granted...Why would he assume that he could tell me it's about 3/8ths, 'cuz I was getting heels made for my shoes? Why would he assume that I would take his 34 word for that and it would be okay? It's common sense that if it's longer than that if the hip is higher and longer than that, then that's what's going to cause other problems, which it has because my back hurt[s]" (Bond, 2022, p. 34-35). The participant stated that the physical therapist most likely assumed that providing just an assumption would suffice his needs and that he took him for granted based on his appearance.

In another incident, a physical therapist refused to examine a patient and instead insisted that there was nothing wrong with her. The participant described the situation stating, "The physical therapist [at Facility B], Caucasian looked at me, didn't examine me, didn't touch me, I'm standing there with the doctor, "There's nothing wrong with her. She doesn't need physical therapy." The doctor never said diddly squat. We turn around with a tail stuck between our legs and walked out. Never got physical therapy...this lady's not quiet, didn't do it in a dark corner. I was...very distressed at the time" (Bond, 2022, p. 32). Leaving her feeling quite distressed (in relation to the *Facing Negative Emotional Experiences* theme), this incident demonstrates how facing appearance/erroneously-based assumptions led to the patient not even receiving treatment.

Additionally, another respondent recalled recalling interactions with her provider concerning treatment compliance. She stated, "If I did [the] exercise that...was given to me and...it was

improvement, it was like, ‘Really?’ You know, like, ‘Really? You actually did these exercises?’ You know, 'cause it was like, it was... [an] amazement type of thing. [The therapist was] surprised... more surprised than anything. And ...that was, I mean, that was more racial...as well as...looking at...my body, you know” (Bond, 2022, p. 31). Here, the patient was subjected to the erroneous assumption that she would not comply with treatment exercises without being given the benefit of the doubt (Bond, 2022, p. 31).

Similar to the previous examples, one last study also presented several instances/codes that aligned with this theme. This item of discourse aimed to examine the impact of perceived racial microaggressions in therapy from the perspective of adult people of color. The study reported that 41.67% of participants’ statements fell under offensive racial microaggressions about identity and/or culture that stemmed from assumptions made by clinical staff. Additionally, the study also found that 50% of participants’ statements related to racial assumptions and/or stereotype made by their therapists. For example, a Black female participant recalled an instance when she gave birth to her first child and upon discussion her therapist automatically assumed that it was due to carelessness or ineffective birth control. The participant recited the interaction as, “‘Do you have any more kids?’ And I [answered], ‘No. I just had a daughter…six months ago, so no, I don’t….have any more kids.’ And then she’s like, ‘Oh,…do you think you’ll have any more kids?’ And I was like, ‘I don’t know. Not right now probably.’ She’s like, ‘Because I know you,’ [and implies] that basically I’m causing stress to myself because I’m not being responsible, and so she’s like, ‘Well, you know you should consider other birth control options so you don’t have any more unplanned pregnancies’” (Okosi, 2018, p. 99).

Overall, this theme presents the common racially stereotyped disadvantage faced by monoracial minorities while also placing it within the perspective of a negatively impacted patient-provider relationship. In analyzing the selected participant responses across the discourse for this theme, there was a notable intersection of patient responses used several times across the other listed themes. These shared responses indicated the possibility that each microaggressive incident may have occurred partially due to the presence of such pervasive stereotypes/erroneous assumptions by clinical staff. This then demonstrates the interconnectedness of each monoracial minority theme.

Facing Negative Emotional Experiences

This theme relates to the wide range of conflicting and negative emotions that patients subjected to such racial microaggressions tend to experience. As displayed throughout the selected discourse, this consists of feeling stressed, humiliated, angry, shocked, distressed, disappointed, disempowered, anxious, dread, invalidated, defeated, exhaustion, vulnerable, and cheated of the high-quality care they deserve (Bond, 2022; Okosi, 2018; Punches et al., 2023; Walls et al., 2015). Unfortunately, having to consistently face such a wide range of emotions when seeking clinical care leads to additional negative consequences. As described by Walls et al. (2015) undergoing such incidents presents more stress in addition to the stress initially present upon seeking healthcare and treatment. This can not only act as an increasingly impactful risk factor for certain health conditions, such as cardiovascular disease but also leaves patients feeling lost and angry as it further confirms there is no space safe from such discrimination (Okosi, 2018; Walls et al., 2015).

In a study that analyzed patients' perceptions of microaggressions and discrimination while treated in the emergency department, researchers included a theme reflecting upon participants' emotional responses to the actions of healthcare staff. Under a list of negative emotions, the

researchers marked feelings of being disturbed, shocked, and feeling vulnerable (Punches et al., 2023).

In a study that aimed to examine the impact of perceived racial microaggressions in therapy from the perspective of adult people of color, a large range of negative emotions was listed based on respondents' statements. Some of the most common emotions listed include anger, shock, frustration, and disappointment. One Black participant recalled an instance where her therapist, rather than taking the time to truly listen to her concerns about racism and sexism in the workplace, dismissed and defended such environments instead. As a result, the participant angrily stated, "I just felt like I was caged. Like she and I [are] here and…I am under this monster of an institution, the hospital, and the school….They should treat me with some respect, [but] I felt like there's no place here that's safe for me. Even the one place that said that I'm supposed to be safe….And then I also felt...so angry that even in another place, which was outside of my department…outside the university,…the racist and sexist structure still got supported!" (Okosi, 2018, p. 102-103). She then continued describing the experience, "Oh, I wanted her to lose her job!...She's…completely ill equipped….She was spilling all this stuff out….You're supposed to be quiet. It's usually quiet. I ain't even gettin' it out good. [The therapist didn't] have any basic attending skills whatsoever….If you didn't like the details, just attend to the emotions. I'm upset, I'm angry, I'm agitated….Even if [she] were to say,… 'Oh, that's a lot, let's just sit here and just breathe.' …You know what I mean?" (Okosi, 2018, p. 103). Similarly, another Black participant described her own experience regarding the wide range of emotions she felt when her therapist presented a mocking attitude towards the traumatic experiences she shared. She stated, "it's just like disappointment, anger, sadness because...this is my life you're talking about. Why are you making a mockery or being

flippant about somebody's life? I just told you these traumatic things happened to me and…I don't feel good about it….You're…a joke as a professional….You put trust in this person to help you, or fix you, and then they're laughing at your pain, so it makes you feel small….I just didn't have any confidence [in him]" (Okosi, 2018, p. 103).

Discrimination Manifests Over Time

Originally placed within the Facing Negative Emotional Experiences theme, this theme also centers around the harmful consequences of experiencing racial microaggressions. However, the distinction between the two themes falls between short- and long-term effects. Contrary to the *Facing Negative Emotional Experiences* theme, this theme relates previous experiences to those experienced specifically within a clinical setting. As demonstrated throughout the introduction and literature review sections, racial microaggressions can occur at any time and any place, and the same individual can experience a multitude of incidences over time. In relation to the selected discourse, these incidences can then trigger past traumas, particularly within a clinical setting.

For example, one study examining the experiences of minority orthopedic patients took note of one respondent recalling interactions with her provider concerning treatment compliance. She stated, "If I did [the] exercise that...was given to me and...it was improvement, it was like, 'Really?' You know, like, 'Really? You actually did these exercises?' You know, 'cause it was like, it was... [an] amazement type of thing. [The therapist was] surprised... more surprised than anything. And ...that was, I mean, that was more racial...as well as...looking at...my body, you know" (Bond, 2022, p. 31). The study claimed that this was a "stark re-traumatization of [the participant's] discriminatory experiences across her lifetime due to her intersecting race and body weight" (Bond, 2022, p. 31).

Another study focusing on patient perceptions of discrimination and satisfaction included a section of participant responses to their experiences of receiving differential treatment based on race, with some even stating that they have come to expect it. One African American participant claimed, “We’re all Black, and we know that there is discrimination and prejudice out there, so we expect that. So you come in there armed, you should come in there armed and ready to deal with that” (Tajeu et al., 2015, p. 2078). The repeated cycle of experiencing daily racial microaggressions in addition to having to prepare to be ‘ready and armed’ for similar experiences in a clinical setting leads to re-traumatization of discriminatory experiences. In addition to potentially traumatizing patients, this cycle then leads to a secondary disadvantage where the patient-provider relationship is negatively impacted.

Undermining Patient-Provider Relationships

This theme presents one of the most wide-ranging and impactful identified disadvantages faced by monoracial minorities upon seeking healthcare. As demonstrated upon each reiteration of participant responses across the discourse in each theme, a high level of intersectionality is presented across the monoracial minority themes. As a result, this final theme, *Undermining Patient-Provider Relationships* stems from the ultimate consequences of facing the disadvantages discussed in each theme. Upon experiencing such incidents of racial discrimination, a wide range of consequences can then develop. This ranges from feelings of defensiveness and/or a pressure to explain to or educate providers, distrusting providers, feeling the need to censor oneself, losing confidence in treatment/care, feelings of power-imbalance, and even eventual termination of treatment.

Starting with the feelings of defensiveness and/or a pressure to explain to or educate providers, in a study that aimed to examine the impact of perceived racial microaggressions in therapy from the perspective of adult people of color provided two suitable examples. One South Asian participant recalled an instance where she felt her therapist dedicated the majority of their session to fit their erroneous assumptions about her culture. The participant stated, "Generally, I felt the microaggressions were...tying things too much to my race, or...cultural identity, and trying to understand my culture, rather than trying to understand me….I particularly remember…one session where I was talking about how I had hung out with my friends, and this one guy that I was really interested in….My friends [had] kind of set it up, so I had thought that there may have been interest on his part too, but he didn't really seem interested….I was…disappointed by that, and this therapist [interjected], "Was it possible that he's gay, because I imagine that in your culture that would be really hard." And then the rest of the session was about how my religion sees homosexuality which is actually, by my interpretation, very positive or very accepting and very pluralistic….I felt…a need to…explain and teach her about that, and we didn't talk about my feelings or my rejection or anything" (Okosi, 2018, p. 94-95). On a related note, some participants reacted to similar circumstances by feeling a sense of pressure to educate providers after providers seemed to focus on their own cultural curiosity rather than the patients' issues at hand. For example, a South Asian participant expressed her feelings towards such incidents, "We kept having these conversations, and…I just answered his questions. Waste of my time. Is this a class about South Asian anthropology? I don't know where this is going. I was frustrated with him" (Okosi, 2018, p. 104). Similarly, another Asian participant recited her experiences with a provider who seemed to be more curious about Chinese culture rather than addressing her needs. This then left the participant unsure whether they both shared the same goals and additionally left her with a

sense of pressure to accommodate to her provider's curiosity. She stated, "I'm not sure what the word for it would be, but I guess I was a little disconnected from her whenever she brought it up…because [it made me] more aware that she was like a person who studied people like me, rather than a person who…understands people in general….It just created a barrier between us" (Okosi, 2018, p. 104).

Upon consistent experiences with racial microaggressions in a clinical setting over a lifetime, many participants feel a sense of distrust toward their provider to truly provide the best quality care. In a study that analyzed domains of dissatisfaction associated with racial/ethnic discrimination among patients with pain, researchers claimed that the third most common code regarding staff demeanor was distrust. One African American participant stated, "I have had my last two treatments at private physicians because the doctors that were [at the VA] are gone and I do not trust people there anymore" (Hausmann, 2020, p. 12).

To prevent the occurrence of racial microaggressions while receiving treatment, participants described feeling the need to censor themselves. For example, in a study aimed to examine the impact of perceived racial microaggressions in therapy from the perspective of adult people of color, one Black participant described her mindset while facing a therapist's dismissive attitude toward discussing perceived discrimination in the workplace. She stated, "I…always remembered…how that made me feel.…But then I realized that there was something wrong…..This was towards the end of the therapy, because I stopped going [when] I felt…I couldn't…be open anymore.…I [thought] let me just keep that to myself then.…He's just not gonna get it, and then that made me feel...why am I in therapy…if I can't just be myself?" (Okosi, 2018, p. 95-96).

To avoid pressurized and uncomfortable circumstances, many patients felt the need to censor themselves. This is an inadvertent result of a power imbalance between patient and provider, where patients feel disempowered and reluctant to be open with their provider due to confusion on how to move forward with these types of situations. Several examples were present in a study aimed to examine the impact of perceived racial microaggressions in therapy from the perspective of adult people of color. For example, a Black participant described feeling a great sense of disempowerment due to an imbalanced patient-provider relationship as well as the location of the counseling session. As the sessions took place within her university's counseling program, she feared that without censoring her true thoughts and feelings, she may be misinterpreted as a danger to the university. She stated, "I…felt …this power imbalance….Can I curse this lady out? If I curse her out, will she tell other people, and then is there some kind of disciplinary thing?...I was unsure what I could actually really say, [what] I really felt, because…I knew that [if] I…came off intimidating or threatening, then maybe she would file a report or something, and then I…would be kicked out of school" (Okosi, 2018, p. 104-105).

This sense of disempowerment/presence of a power imbalance is also applicable under conflicting circumstances where patients are considering addressing the issues of racial microaggressions with their providers. However, in being exposed to this awkward power imbalance with providers, many patients then find themselves at a crossroads, where they must weigh the possibility of receiving lower care versus expressing their feelings. For instance, 41.67% of participants in the previously mentioned study reported anticipation of poor outcomes with their provider if they were to stir discussion. One type of anticipated poor outcome shared by participants was that their therapists would not be able to understand their perspective, resulting in

even further patient frustration. One Black participant stated, “If he couldn’t even understand where I was coming from when I was talking about [presenting] issues, then how was he gonna understand [the more complex process discussion]? Like, ‘Oh hey,…I feel uncomfortable now, because I can’t just say what I really wanna say ’cause you’re not gonna really…acknowledge it’” (Okosi, 2018, p. 111). Similarly, another Black participant discussed how she felt that due to her therapist’s prejudices, they would not be able to understand her concerns. She stated, “I didn’t bother, because I didn’t think he would understand or care. He was an old, old Jamaican doctor, with light skin. I feel based on his age and where he was from, he was classist, and was judging me based on the color of my skin. Those old-school upper-class Jamaicans from back then were all about class and color. I’ve dealt with those types before. I’m sure he expected me to have these issues living [where I did] and being from a lower income family” (Okosi, 2018, p. 111). Additionally, other poor anticipated outcomes stemmed from guilt/fear that discussing such issues would hurt their therapists’ feelings and that avoiding such discussions was much more tolerable. For example, one South Asian participant stated, “I didn’t want him to feel like he didn’t get me. I felt bad. I didn’t want him to feel bad” (Okosi, 2018, p. 111). Similarly, another South Asian participant stated, “I felt really guilty about that….I felt like my obligation as a therapist was to tell her so she could do better….I just had a sense that she would just try to defend herself…in an empathetic way, I’m sure, but not really get what I meant and…I always have trouble...communicating feedback or criticism or [even] constructive…things to people. I don’t like to upset them, and I didn’t want to deal with her potentially being upset. It was easier to leave” (Okosi, 2018, p. 112). A more direct example of the impact power dynamic has on the ability to discuss such issues was seen with a Black participant who stated, “I brought up the power dynamics [in response to the question] because then I wanted to react [because I was] very angry

about how she's invalidating my experiences. But I wasn't sure at that time of…how these sessions work. So that also prevented me, but in later sessions, [as] I advanced through my various degrees….I started…asking them more questions than they were asking me" (Okosi, 2018, p. 113). Similarly, another Asian participant described her experiences as, "[I didn't respond because of] the power dynamic….She was the one who had finished the…training, and for me to question her would have felt like…questioning an authority. Although…in our relationship, she wasn't really an authority, but it felt like [she was]. I have issues with authority, so I didn't want to…question her, and be like, "Yo, why are you doing this?" So…that's what stopped me, I guess" (Okosi, 2018, p. 114). Lastly, in a study that analyzed patients' perceptions of microaggressions and discrimination while treated in the emergency department, many participants were hesitant to bring forth their issues with perceived racial microaggressions. This was largely due to: not wanting to directly identify/call out staff members, assuming no action would be taken, or fear/concern that their medical treatment would be negatively affected (Punches et al., 2023).

In a further consequence of experiencing racial microaggressions during treatment and the previously listed undermining factors of this relationship, the discourse demonstrated how participants seem to lose confidence in receiving proper treatment/care, which can ultimately lead to the termination of treatment altogether. For example, in a study that analyzed patients' perceptions of microaggressions and discrimination while treated in the emergency department, one of the major themes formed in attribution to consequential emotional responses stated, "he respondents describe vivid reactions to previous negative clinician behaviors including saying that they were "disturbed" and "shocked" and "felt vulnerable" and that they questioned whether to leave the ED before the completion of their care" (Punches et al., 2023, p. 1198). A study that

aimed to examine the impact of perceived racial microaggressions in therapy from the perspective of adult people of color provided several examples. For instance, a Black participant stated, "[When the therapist stated] 'I have several Black friends,'…that was…one of my first, and not last, and probably more encounters to come in the future of,…White people saying [things like this], I guess to validate how they're not racist because they know Black people. So…after that experience, between her making comments about my body, and then comments about my pregnancy, and how I shouldn't have any more kids…and then that comment about "Oh, my Black friend is one of the advisors," I was…done for that session and…seeking any counseling" (Okosi, 2018, p. 98). Similarly, another Black participant described how she lost confidence or trust in her therapist after mocking her shared traumatic experiences. She stated, "If it happened to someone else, I would laugh. It's happening to me, and I'm laughing but also like, No that's not funny. What is he doing? That's inappropriate. Shock [was my reaction] initially, and then after [he] continued [with the] the session, it's just like disappointment, anger, sadness because...this is my life you're talking about. Why are you making a mockery or being flippant about somebody's life? I just told you these traumatic things happened to me and…I don't feel good about it….You're…a joke as a professional….You put trust in this person to help you, or fix you, and then they're laughing at your pain, so it makes you feel small….I just didn't have any confidence [in him]" (Okosi, 2018, p. 103). As demonstrated, experiencing racial microaggressions while receiving treatment can then lead to patients terminating treatment altogether, which then increases the risk of disease complications and worsening conditions (Punches et al., 2023; Walls et al., 2015).

Overall, it can be determined that facing such racial microaggressions can lead to a multitude of issues that may weaken relationships between patients and providers. As patients continue to

lose confidence and trust, they may resort to avoiding such stressful circumstances altogether through the termination of treatment. As demonstrated by Walls et al., this could then "impact helpseeking behaviors such as scheduling and attending regular physician or clinic appointments. This could in turn result the worsening of health conditions that increase risk of hospitalization" (Walls et al., 2015, p. 237).

Multiracial Themes

Providers Lack Experience with Patients of Mixed Race

This theme centers around the issue that a large portion of providers lack experience with caring for and treating people of color, specifically those who are mixed race. Two main issues surfaced upon examination of this theme: lack of understanding and lack of workforce diversity. With the first issue, patients felt that a lack of provider experience with patients of such racial backgrounds then causes providers to struggle to make connections to the experiences and health disparities of people of color. Furthermore, some patients worried that their provider would not be able to identify health issues that disproportionately impact some races or ethnicities more than others. This would then leave their concerns prone to not being taken seriously and therefore lead to a lower quality of care. In a study that aimed to gain a greater understanding of multiracial patients' provider preferences, one Japanese participant noted her concerns about providers understanding health issue disproportionality. She stated, "I may choose someone who understands common health problems Japanese people have and that take my concerns seriously" (Snyder & Truitt, 2020, p. 481). Similarly, another participant shared concerns about the lack of providers that are both experienced and comfortable working with racial and ethnic minority people of color. They stated, "It plays into my decision in that I want to choose a provider who has experience

working with people of many backgrounds. I look for someone who will not be discriminatory, but I don't seek out any particular race" (Snyder & Truitt, 2020, p. 481). This lack of understanding and connection to mixed-race patient experiences/challenges is not only an isolating experience but can leave patients less inclined to seek medical care.

Another factor that further plays into the lack of experience of providers in treating mixed-race patients is due to a lack of workforce diversity. Throughout much of the selected discourse, many participants discussed their struggle to find/have access to providers of similar racial or ethnic backgrounds. In reference to the previously listed study, the researchers highlighted patients' emphasis on the importance of having providers whom they could relate to and connect with, most likely being with a person from the same racial background. For example, one participant stated, "I do target more providers that have an Asian background. So, it's regardless whether they're Chinese or Japanese or Thai. As long as they're Asian, I feel like there's some sort of cultural overlap that I don't need to quite say out loud or in terms of mannerisms, I don't have to code switch. So, it just feels more familiar to me" (Snyder & Truitt, 2020, p. 481). Another participant described their preference and struggle to find racial minority providers. They stated, "As my mixed-race identity is so salient for who I am, I tend to gravitate towards ethnic racial minority health care providers -though I have to be honest - I rarely come across them" (Snyder & Truitt, 2020, p. 481). On a similar note, another study that aimed to investigate the multiracial experience in therapy reported that participants "commented on the lack of diversity of counselors and staff and remarked that the environment felt like a 'White' space" (Foster et al., 2014, p. 20). Additionally, another study that explored young multiracial adults' experiences in seeking healthcare in the U.S. also noted that several participants acknowledged a lack of access to

providers of similar racial or ethnic backgrounds made it increasingly difficult to attain proper care. One participant stated, "…I guess it was kind of off-putting to know I only had two options, and the option or the doctor who was a woman of color only has appointments available for two months out" (Vora & Grilo, 2023, p. 8). Similarly, another participant provided the statement: "…I avoid it [mental health services] now because I just—I know that there's no-one there that I can speak to—can speak to—can understand where I'm coming from, particularly around mixed race, not just being a woman of color, but the particular challenges of duality constantly, or multiplicity constantly" (Vora & Grilo, 2023, p. 8). Overall, this not only made it more difficult to find providers that they could connect with but also further made them less likely to seek proper medical care (Vora & Grilo, 2023).

Providers Dismiss/Avoid Discussing Race

This theme serves as a direct consequence of the previous theme, *Providers Lack Experience with Patients of Mixed Race*. With a lack of experience or knowledge on a certain topic, specifically relating to mixed-race people of color, many patients noticed how their providers seemed dismissive and avoided such topics. This was best represented in a study that aimed to investigate the experiences of multiracial individuals in therapy, which based on the high frequency of linked codes, included an entire subtheme based on provider avoidance and minimization of race in therapy. The researchers stated how many participants had attempted to discuss their multiracial identity with providers, but were met with little to no response. From the participants' perspectives, this insinuated the therapists' lack of knowledge, discomfort, and inability to relate, all of which were similar claims displayed in the monoracial minority theme, *Undermining Patient-Provider Relationships*. One participant stated, "I would have to explain to people, 'No, I'm of mixed race.'

And that conversation would have to go to a whole 'nother deal -- it was almost as if, 'Okay well I don't have any tools in my toolbox to deal with that one so let's move on.' You know what I'm saying? It was like, 'oh we have to ask it for demographic purposes, but we're not going to get deep into that mess'" (Foster et al., 2014, p. 15). Additionally, providers seemed unresponsive, unable to relate to their patients, and demonstrated discomfort through various unconscious or nonverbal communication. This includes shifting body posture, becoming flushed, changes in breathing patterns, and even laughter. One participant recalled an instance where she attempted to discuss her multiracial identity early on within the patient-therapist relationship. She stated, "I think she laughed. She laughed. 'That's cool,' and laughed. Yeah. Something like that…I don't know, I feel like it's what people do with their shame and their discomfort when they can't put me into a box" (Foster et al., 2014, p. 15). Patients also noted how providers would immediately change the subject almost as if they were rushing past any sort of discussion, or would only give 'textbook' responses to avoid further engaging the topic such as "that sounds hard" or "yeah" (Foster, 2014, p. 16). This further insinuated therapists' lack of knowledge and discomfort with topic concerning multiraciality. For example, one participant stated, "I can't remember her specifically acknowledging any of it, more than beyond like saying 'yeah' or verbal cues that she's listening… 'Just, an inability to even recognize that race may impact my life, I', guessing she saw me as similar, she saw me as part Caucasian and that was the part she identified with and sort of based her therapy and her interaction with me on, is what I would guess" (Foster et al., 2014, p. 16). This consistent minimization and avoidance then led patients to feel as if providers did not want or care "to establish safety or to recognize the emotional intensity of talking about complex issues of identity" (Foster, 2014, p. 16).

Negative Impact of Avoidance of Racial Discussions

This theme focuses on the direct impact of the previous theme, *Providers Dismiss/Avoid Discussing Race*, on patients and explores the negative emotional experiences that stem from such experiences. Specifically, in a study that aimed to investigate the experiences of multiracial individuals in therapy, many participants expressed feelings of frustration towards therapists' acts of avoidance. One common act of avoidance relates to when therapists seem to dedicate more time and emphasize the importance of exploring other issues while simultaneously dismissing any topics related to multiracial reality. Similarly demonstrated in the monoracial minority theme, *Facing Negative Emotional Experiences*, in witnessing providers increasingly become uncomfortable or dismissive conveyed the message that discussing race was an off-limits topic in therapy (Foster et al., 2014). As demonstrated in a study that aimed to identify how racial microaggressions manifest for multiracial individuals, many participants had felt disappointed and surprised about the lack of acknowledgment or engagement in conversations about race and culture. One participant stated, "I just feel like it [culture] is such an important part to my experience and to my kids' experience of how they experience the world; but, it's never brought up in our medical conversations. And, so, it does just feel like it's an ignored part, and like we are sort of just all supposed to be the same, without this acknowledgment that there are differences" (Snyder et al., 2018, p. 234).

During times when the topic of multiracial reality was acknowledged, participants still felt as if providers were avoiding any deep discussion by utilizing 'textbook responses'. The researchers stated, 'they noticed their therapists using generic statements like 'that sounds hard,' rather than responding to their specific concerns around racial identity, discrimination, and family dynamics

complicated by cultural clashes and systemic racism" (Foster et al., 2014, p. 16). From the participant's perspective, this only further highlighted the provider's lack of knowledge on such topics and their discomfort. For example, one participant stated, "I can't remember her specifically acknowledging any of it, more than beyond like saying, 'yeah,' or verbal cues that she's listening… 'Just, an inability to even recognize that race may impact my life, I', guessing she saw me as similar, she saw me as part Caucasian and that was the part she identified with and sort of based her therapy and her interaction with me on, is what I would guess" (Foster et al., 2014, p. 16). During other instances of provider acknowledgment, other participants felt that providers tended to move through such topics too quickly, "not taking care to establish safety or to recognize the emotional intensity of talking about complex issues of identity" (Foster et al., 2014, p. 16). For example, one participant recalled feeling a sense of overwhelming pressure to open up about her private and painful experiences with her racial identity with a therapist she did not trust yet. She stated, "Like 'whoa!' I don't know… I'm just not open with you, like I have to be comfortable before I start telling you stuff… You can't just assume, that just because I'm different racially that I'm going to have problems with it. I mean I was having problems with it, but since she like put it out, I was just like goddamn, I did not want to talk about this today" (Foster et al., 2014, p. 16). This negatively impactful experience ultimately resulted in the participant's termination of treatment. Overall, many participants from this study felt that such provider actions conveyed the message that therapy was not the correct place to discuss issues concerning racial identity, racial discrimination, and most in particular, multiracial identity (Foster et al., 2014, p. 21).

Presence of 6 Medical Institutional Racial Microaggressions

This theme relates to the presence of the six racial microaggressions that multiracial individuals tend to experience within medical institutions. Here, participants noted the presence of *mistaken*

identity of one or incorrect race, mistaken relationships, fixed forms, entitled examiner, and pervasive stereotypes (Snyder et al., 2018; Vora & Grilo, 2023). It should be noted that intersectionality was not listed within this theme as it does not directly relate to racial microaggressions, rather it aims to incorporate other areas of possible microaggressions such as gender, age, etc.

Several items of discourse presented instances of *mistaken identity* from participants' experiences. This type of microaggression stems from appearance-based assumptions of being associated with only one racial identity. As demonstrated by a study that aimed to identify and describe how racial microaggressions manifest for multiracial individuals, many participants described how providers would assume they only had one racial identity and even documented them in medical records. For example, one participant stated, "Recently in the online patient portal I noticed that my race was listed as white. I was so mad! I emailed them saying I can only assume that they assigned me white based on my appearance" (Snyder et al., 2018, p. 232). Similarly, another patient described her experience with mistaken medical records. She stated, "This relates to an experience I had approximately 10 years ago where I went in for an HIV AIDS test. I returned for my results (as is required) and was sitting with the provider who reported my results (negative) and pointed to the form where the results were listed. I noticed on the form that I was identified as a 'white female.' I was perplexed and assumed that the results that were reported on the form were not meant for me as I did not identify myself as white. I did not say anything to the counselor and left the meeting assuming she gave me the wrong results and I might really be HIV-positive" (Snyder et al., 2018, p. 233).

Mistaken Relationships refer to when providers or other clinical staff assume patients and family members are not related. As demonstrated by the previously mentioned study, one patient stated "I remember the discomfort that my dad, when he would take me into the doctor when I was younger, that they'd [clinic staff] be like, 'Oh, is this your new adopted child? What's your relationship to this child?' And, it's such an awkward moment for him and myself" (Snyder et al., 2018, p. 233). This type of microaggression also conveys the message that all family members should look alike, and that if they do not they must be adopted. One participant described how experiencing such instances made them feel. They stated, "I feel like the fact that my family members aren't seen as being family and being truly related to me takes away from my ability to see them as a support system because instead I'm seeing them as a choice I have to defend. Yes, this is my mom, I did bring her because she's related to me and I love her, and I need her to help me" (Snyder et al., 2018, p. 233).

Fixed Forms refer to when medical forms are not structured to allow for the selection of more than one race or offer 'multiracial' as an option for patients to fill out. In the previously mentioned study, one participant stated, "although many providers have updated their [intake forms], some still don't provide an option to check multiracial/mixed-race" (Snyder et al., 2018, p. 233).

Entitled Examiner focuses on the relationship between patients and providers, mostly directed towards the power imbalance that can form. Similar to the consequences listed in the monoracial minority theme, *Undermining Patient-Provider Relationships*, patients have noted that providers ask questions that may seem inappropriate or invasive outside of the clinical setting. For example, one participant recalled an instance where he experienced this microaggression when attending an appointment with his multiracial children. He stated, "There's always a question as to 'Are you

the father type of thing, or are you the husband?' And I don't know what that means? You know, I'm assuming they're just asking to find out who I am. I would be lying if in the back of my mind I didn't wonder what they —if there's anything else to it" (Snyder et al., 2018, p. 234). Additionally, due to this relationship's power imbalance, participants have noted that providers may tend to ask invasive questions that reflect potential biases. For example, several participants recall constantly being asked about their blood quantum. One participant stated, "I also tend to get the question of 'how much' of a native I am, but I'm never asked how much of anything else I am" (Snyder et al., 2018, p. 234).

Similar to the monoracial minority theme, *Facing Racial/Cultural Stereotypes from Staff*, *Pervasive Stereotypes* relate to assumptions based on financial status, education, and insurance due to racial biases or stereotypes. As demonstrated by the previously listed study, this results in a shift in the manner of provider communication. As one participant stated, "I think I've had numerous times, and I don't know if this is race or age or what, but numerous times people are all of a sudden, 'Oh, you have a Ph.D.?' and then, all of a sudden, they feel like they can talk to me in a completely different way about what's going on with me even" (Snyder et al., 2018, p. 234). Additionally, several participants also stated that the clothes they wore to their appointments seemed to affect the way providers communicated with them. For example, one participant stated, "We have noticed that the folks at [the hospital] treat us differently based upon the clothes that we're wearing. That if I go in my work clothes and my husband goes in his work clothes, we are treated as having a certain level of competency. They didn't go into a great deal to explain things" (Snyder et al., 2018, p. 234). This demonstrates how providers make automatic assumptions about participants' educational and financial status based on what they are wearing. Another study that

aimed to investigate the experiences of multiracial individuals in therapy also showed similar results regarding stereotypical assumptions made based on race. In contrast to the experiences listed under the monoracial minority theme, *Facing Racial/Cultural Stereotypes from Staff*, provider stereotypes appeared to stem from the racial group participants were assumed to be part of, rather than being based on multiracial identity. The discourse item stated, "participants who reported being typically perceived as Black experienced assumptions of criminality, ascription of inferior intelligence, and assumptions of hypersexuality whereas a participant who was perceived as Asian was stereotyped as being religious on the basis of her race" (Foster et al., 2014, p. 18-19).

In addition to the presence of the six racial microaggressions that multiracial individuals face in healthcare settings, there was also an increasing presence of denial of multiracial reality, a racial microaggression commonly experienced in day-to-day life. Within a medical context, this racial microaggression results in providers failing to acknowledge/recognize the differences in challenges faced by multiracial individuals in a world that "privileges monoracial identities" (Foster et al., 2014, p. 17). For example, a Black/White biracial woman recalled a time when her therapist often encouraged her to spend more time with her Black friends, but had never taken the time to acknowledge the difficulty of doing so. She stated, "She was trying – she would try to push me outside my comfort zone. But everyone was pushing me back. She was like, 'Oh yeah you need to go do this. But you didn't, so oh well, guess you're stuck with the White people.' And so I didn't really feel like I should – [long pause] that I was working with her" (Foster et al., 2014, p. 17). Another racial microaggression that is commonly experienced in day-to-day life of monoracial minorities that also appeared in the previously mentioned study was the *Second-class Status and Treatment of Multiracial People*. This microaggression was associated with participants' note of a

lack of diversity in providers, which was previously listed as an issue held by multiracial patients throughout the multiracial thematic results. In this study, "participants who attended counseling through university mental health centers and community mental health clinics commented on the lack of diversity of counselors and staff and remarked the environment felt like a 'White' space" (Foster et al., 2014, p. 20).

Impact of 6 Medical Institutional Racial Microaggressions

Similar to the theme discussing the direct impact of lack of provider experience on patients, this theme focuses on the direct impact of the medical institutional racial microaggressions on patients as well. In a study that aimed to identify how racial microaggressions manifest for multiracial individuals, *mistaken relationships* was described as a microaggression where providers mistakenly make assumptions about a patient's familial relationships. In a result of the instances described by the quotes provided in the previous section, participants stated that they felt awkward, uncomfortable, and the need to defend familial relationships due to such assumptions or questioning. Specifically, several participants described feeling excluded or isolated from their own families. While facing such isolation is quite common in daily life experiences for multiracial individuals, it can have a much greater, or more intensified effect on patients. As demonstrated by the study, "in healthcare, people often felt a need or desire for family support related to the circumstances of seeking health care with a family member – whether in supporting a relative's care or in receiving support during one's own health care" (Snyder et al., 2018, p. 235). For many participants, this intensified effect posed a negative impact, which made it more difficult to come to medical decisions and also felt disempowering.

In experiencing the *entitled examiner* microaggression, a study that aimed to identify how racial microaggressions manifest for multiracial individuals reported that the participants have learned to expect inappropriate or invasive questions from clinical staff. This is in part because this is also a common microaggression that multiracial individuals face day to day. However, questions that participants may deem inappropriate in other scenarios have shown to be quite difficult to navigate within a clinical setting. Due to the power dynamic between patients and providers, it can be quite difficult to distinguish what questions are based on provider curiosity or racial bias versus what questions are needed for accurate medical treatment. Specifically, patients reported feeling uncertain about whether they could avoid answering inappropriate questions as well as the extent to which questions were for treatment or their providers' own curiosity (Snyder et al., 2018).

In experiencing *pervasive stereotypes*, many participants from the previously listed study felt objectified, an effect that only seemed to appear for multiracial individuals. Specifically, a majority of clinical staff comments were appearance-based. For example, one participant recalled a moment when clinical staff commented on her multiracial daughter, "'She's just so beautiful. What a unique look. She's going to grow up to look like Beyoncé.' Just weird stuff. Where I'm like, she just looks like any other mixed-race baby. I don't know why she's exotic" (Snyder et al., 2018, p. 235). After experiencing such encounters, many participants felt uncomfortable and awkward (Snyder et al., 2018). Additionally, the presence of *pervasive stereotypes* adds a secondary negative impact of adding discomfort and confusion on whether they should confront the aggressor as these messages are often given with positive intentions. For example, one participant described how her therapist stated that they relate to Indian culture after she had openly identified as a biracial White/Native

American female. She stated, “I felt the discomfort of not really knowing what to do. Yeah, I get the sense like she wanted me to feel like she understood something about me, but it was just very stereotypical. There’s a huge variance from tribe to tribe” (Foster et al., 2014, p. 19). While such encounters are quite common for multiracial individuals, many participants expressed disappointment and were surprised as they did not expect these ‘typical’ microaggressions from therapists (Foster et al., 2014).

In experiencing underlying assumptions based on appearances, one study that explored young multiracial adults' experiences in seeking healthcare in the U.S. described how it is “associated with increased report of emotional and physical symptoms related to racial discrimination” (Vora & Grilo, 2023, p. 10). This was particularly present against those who identified with races commonly associated with a ‘lower status’. One study that aimed to investigate the experiences of multiracial individuals in therapy stated, “participants who reported being typically perceived as Black experienced assumptions of criminality, ascription of inferior intelligence, and assumptions of hypersexuality whereas a participant who was perceived as Asian was stereotyped as being religious on the basis of her race” (Foster, 2014, p. 18-19). One unique occurrence that appeared only to be experienced by multiracial patients, particularly children, is a differential treatment based on which parent is present. This was demonstrated by a study that aimed to identify the barriers and facilitators of people with down syndrome who are Black, African American, of African Descent, or of mixed race. The researchers listed the experiences of one parent of a biracial child of Black and Caucasian descent as, “When attending an appointment with his mother, he is treated with less respect, and procedures are not explain[ed] thoroughly and questions are not treat[ed] [with] respect or concern” (Krell et al., 2022, p. 748-749).

In being denied multiracial reality, many participants from a study that aimed to investigate the experiences of multiracial individuals in therapy felt an extreme sense of isolation. While this feeling is not uncommon compared to the daily-life experiences that multiracial individuals tend to face in any other environment, attempting to discuss such experiences poses its own challenges within a healthcare or particularly a therapeutic setting. In trying to discuss such experiences with therapists, many participants felt they were skeptical and minimized the experiences. Upon being questioned about multiracial identity/reality, many participants felt this was invalidating. For example, one participant described how her therapist stated that she "had the best of both worlds" (Foster et al., 2014, p. 17). This is commonly regarded as an insensitive statement, as it is dismissive of complications individuals may face when attempting to address multiracial dynamics in their daily lives. Additionally, many participants felt that therapists tended to blame, judge, invalidate experiences, or claim that they were overly sensitive when attempting to discuss multiracial-related topics. For example, one participant stated how whenever she would attempt to discuss racial issues, her therapist would constantly redirect the conversation to convey the message that she was the source of the issue. She stated, "If I saw that at work that I feel like I'm not safe then, it's been about: *[in soft voice]* 'Oh well, when else have you not felt safe?' or like, 'When did you get that message growing up?' But not around race. Like a clear shift of focus from that. Like that's not really what it's about, you know?" (Foster et al, 2014, p. 18). The study then acknowledged how during participant interviews, discussing such topics was a painful and vulnerable experience that stirred intense emotions. Many had felt that "their therapists lacked empathy and sensitivity in their responses. In the interview, they expressed frustration, sadness, and disappointment that therapy became another place in which the authenticity of their racial realities was called into question" (Foster et al, 2014, p. 18).

The previously listed study also included a section addressing the overall impact of experiencing such microaggressions. Over time, participants reported experiencing emotional reactions, became guarded and withdrawn, tried to strategize conversations, and even terminated treatment altogether. When patients experience such racial microaggressions during therapy, many were left feeling increasingly worse feeling hurt, disappointed, guilty, and confused. Further, many participants also felt surprised that they experienced microaggressions in a place where they hoped to consider a safe space for discussion. In leaving such sessions, participants recall feeling unheard, blamed, criticized, and alone. One participant stated, "I became much more – I became much more reclusive I would say, like I kind of spent most of my time by myself. I started journaling a lot more, but I was doing the kind of – like taking it into my own hands of ways to kind of get all of my thoughts and emotions out, because I didn't really have anybody to talk to about it" (Foster et al., 2014, p. 26). Additionally, confusion stemmed from the conflict that the therapists seemed to convey messages with positive intentions yet still presented invalidating stereotypical statements. For example, one participant stated, "I felt like it was good, but it wasn't all that helpful because I felt like she was condescending. She made me feel guilty about my actions and my personal life. And it was helpful because I learned different things. I also got the technique and tools to be able to overcome – certain things. But in the end I felt like she, like she helped but she didn't help me" (Foster et al., 2014, p. 26). One of the biggest consequences of experiencing these racial microaggressions on patients are the feelings of uncertainty and discomfort of how to address such situations. As these racial microaggressions are often seen as being communicated with positive intentions, many patients found confrontation difficult and questioned whether they had perceived the microaggressions in the first place. Another concern participants had about confrontation was the possibility that they would hurt providers' feelings or further negatively impact the power

dynamic. Additionally, other participants worried that by confronting such racial issues, they would inadvertently be confirming certain racial stereotypes about their race such as being hypersensitive, aggressive, or overly focused on racial topics. For example, one participant stated, " I don't want people to think I'm a bad person. Just when I get defensive, I get really upset and I'll start cursing or something. That's how you know when I'm upset, I just don't like bringing that side out. Because it – I don't know, sometimes it reminds me of my mom and like, her African American side. People, I just don't want them to call me ghetto or something" (Foster et al., 2014, p. 27).

In becoming increasingly guarded around topics of race with their therapists, participants recall often attempting to strategize to cater to the therapists' 'needs'. This included accounting for racial background, identifying cues/indicators for what topics would be understood and those that would not, and personally responding to racial microaggressive incidents using coping mechanisms or becoming withdrawn. One participant described the behavior of their therapist during racial discussions as, "Standoffish. Attitude problems. It's like, 'whatever man, get this over with,' type of situation. Like, 'yeah you don't understand, just keep it moving.' Being, um, surface-oriented, a little less deep, a little less open. A lot less open" (Foster et al., 2014, p. 27). As a result, participants largely made efforts to 'compartmentalize' racial topics in therapy, and rather only focusing on topics they felt that their therapists could understand, specifically stand-alone mental health issues. For example, one participant stated, "It's your counselor so you don't think, "Oh this person is going to be racist or inappropriate." But why open that door for another opportunity? I don't want to walk into a situation where I might experience some kind of microaggression from my therapist" (Foster et al., 2014, p. 28). One notable behavior of multiracial participants was that

as a result of the previously listed impacts and corresponding behaviors, participants would make an effort to only shift to or highlight the parts of their identities that best catered to their therapists' identities/needs. For example, one Black/White biracial male participant recalled how he would often shift his communication/identity when working with his Black psychologist. He stated, "I have a Black side. Because I have that overcompensating Black person in me, I'm able to – when I sit down with a psychologist, I almost feel like I'm giving them therapy. And it's – [laughs] – you know, it can be frustrating, but I'm giving you an ability to feel comfortable about who you are in talking to me. Yeah, dude. I have my White voice and I have my Black voice. I mean it's like I'm a fucking chameleon sometimes" (Foster et al., 2014, p. 28).

In having to experience such racial microaggressions during therapeutic treatment, many participants felt that this limited the potential helpfulness that therapy could have offered them. This was largely due to participants' feeling the need to strategize or censor their conversations to cater to therapists' comfort. For example, one participant stated, "And so it felt like the – even the meaning and the depth of the therapy was – it felt superficial to me, it felt like this is…this is for them" (Foster et al., 2014, p. 28).

In some situations, some participants eventually reached a breaking point with facing the impacts of racial microaggressions and terminated treatment altogether. For example, one participant recalled how she eventually came to start avoiding appointments after feeling judged and shamed. She stated, "And so I stopped going to her. I started giving her excuses like 'Oh, no I need to study I can't come to your meetings.' When in reality I'm walking past the building… canceling my appointment like, 'I'm sorry I can't make it, I'm studying right now, I'm swamped' or 'I'm sick.' And in reality I was just walking by the building" (Foster et al., 2014, p. 29). This

then further creates issues of healthcare underutilization and the increasing chances of health risks in the future (Foster et al., 2014). Additionally, this also left participants feeling less likely to seek therapy again in life (Foster et al., 2014).

Patients' Mistrust of Providers

Similar to the *Undermining Patient-Provider Relationships* monoracial minority theme, this theme centers around the fact that by undergoing all the disadvantages and experiences listed above, patients eventually stop entrusting their providers to provide high-quality care and instead come to expect such treatment (Snyder et al., 2018). As stated by a participant from a study that aimed to investigate the multiracial experience in therapy, "I don't trust them. I fundamentally feel like I'm not getting treated the same when it comes to healthcare and like the care I'm getting as—I mean, I'm just gonna be honest like as White people" (Vora & Grilo, 2023, p. 8). As patients start to expect such treatment, some may eventually feel the need to 'code switch', where "any member of a marginalized or underrepresented identity adapting to the dominant environment around them in any context" (Washington-Harmon, 2024). This is showcased by a participant from a study that aimed to understand multiracial patients' preferences in choosing a healthcare provider. The participant stated, "As long as they're Asian, I feel like there's some sort of cultural overlap that I don't need to quite say out loud or in terms of mannerisms, I don't have to code switch. So, it just feels more familiar to me" (Snyder & Truitt, 2020, p. 481) in response to expressing their preference for providers.

Additionally, within a medical context in the presence of providers of a different race, patients may feel the need to code-switch to feel better understood, taken seriously, and possibly prevent the occurrence of racial microaggressions (Snyder & Truitt, 2020). In terms of patient mistrust in

providers, some individuals feel the need to dress differently, as many patients claim that the clothes they wear heavily impact provider communication. For example, in a study that aimed to identify and describe the manifestation of racial microaggressions for multiracial individuals, a participant stated, “We have noticed that the folks at [the hospital] treat us differently based upon the clothes that we’re wearing. That if I go in my work clothes and my husband goes in his work clothes, we are treated as having a certain level of competency. They didn’t go into a great deal to explain thing” (Snyder et al., 2018, p. 234).

Impact on Multiracial Identity

This theme presents a unique consequence of facing racial microaggressions as a multiracial/mixed-race individual. Particularly within clinical settings under an unevenly distributed power dynamic between patients and providers, such experiences can have an increased impact on the identity of multiracials. As described by a study that aimed to investigate the experiences of multiracial individuals in therapy, many multiracial individuals may “hold a ‘private’ identity that does not necessarily match their physical appearance and that may be different from the identity that they most often claim publicly” (Foster et al., 2014, p. 33). The study further states how “multiracial identities are often socially contested and highly influenced by factors over which individuals have little control, such as physical appearance, geographical context, and family dynamics. Claiming certain identities publicly carries a risk of social rejection, has political implications, and may even feel like a betrayal of one’s ethnic heritage” (Foster et al., 2014, p. 33). This highlights the importance of having a private, safe space to talk about such difficulties, showing how therapy would allow these individuals to voice their worries/concerns and grow. In being subjected to constant racial microaggressions, particularly within a clinical setting, this can further negatively impact the intersectional identity crisis individuals face in

combination with historical racism within the United States and generational trauma (Vora & Grilo, 2023). One example was presented in a study that aimed to identify how racial microaggressions manifest for multiracial individuals. In elaborating upon the *fixed forms* microaggression, many patients felt as if they were forced to choose to identify only with one side of themselves (Snyder et al., 2018).

Another uniquely inadvertent consequence of providers having a lack of experience with mixed-race clients is the idealization of multiracial individuals. As demonstrated by a study that aimed to investigate experiences of multiracial individuals in therapy, in lacking such experience with mixed race clients, in an attempt to better connect with patients, providers may unintentionally communicate the belief that "multiracial individuals represent 'the future of America', are 'beyond race', or 'have the best of both worlds'" (Foster et al., 2014, p. 34). Such messages then appear to demean monoracial identities, which in turn serves as its own racial microaggression.

Furthermore, another inadvertent consequence of constantly being dismissed from racial discussions is that when providers did attempt to discuss the topic, this in turn created a different issue where patients struggled to answer questions they had never been given the opportunity to think and reflect deeply about. As demonstrated from the previously listed study, participants felt that were never 'allowed' to reflect on the extent of how being of mixed race/multiracial can impact their lives (Foster, 2014). Additionally, participants from a study that aimed to identify how racial microaggressions manifest for multiracial individuals expressed disappointment in providers for failing to create a safe space for patients to make such connections and how infrequently such topics are addressed within clinical settings (Snyder et al., 2018).

DISCUSSION

Overview

Overall, this study aimed to qualitatively identify and understand the common disadvantages faced by multiracial individuals in comparison to monoracial minorities concerning racial microaggressions when receiving healthcare. Once again, the posed research question was stated as: are patients who identify as multiracial subjected to facing a unique set of racial microaggressions compared to monoracial minority patients when seeking healthcare in the U.S? The resulting methods/procedure consisted of a critical discourse analysis used to identify themes of such microaggressions for both monoracial minorities and multiracial individuals within a healthcare setting. In abiding by the procedure listed in the methods section, a total of eleven items of discourse were determined to have met the listed criteria, with six falling under the monoracial minority perspective and five falling under the multiracial minority perspective. It should be noted that a majority of the selected discourse involved analyses of patient-therapist relationships. As successful therapeutic treatment is shaped by proper communication between patients and providers, one could argue that this is where many racial microaggressions could potentially take place (Sutton, 2023). The analysis resulted in the generation of six themes for monoracial minorities and seven themes for multiracial minorities that were determined to best reflect the overall experiences of both demographics. A key pattern that can be found within both thematic subsections is the division between themes that reflect either actions or consequences. A more specified explanation of this observation will be placed in the analyses below. The findings of this analysis displayed that multiracial minorities experience both similar and different racial

microaggressions compared to monoracial minorities when receiving healthcare and are therefore supporting the hypothesis.

Monoracial Minority Themes Analysis

In analyzing the *Monoracial Minority Themes*, an immediate connection was made with the descriptions listed in the section, *Racial Microaggressions in Medical Institutions: Monoracial Minority Experiences*, located within the literature review. A noticeable consistency was present with the thematic findings in that the discourse provided further evidence that racial minorities experience lower levels of communication and negatively explicit attitudes from physicians. In addition, most findings reported subtle actions or exchanges between patients and physicians where patients increasingly felt ignored, insulted, or disrespected (Ross et al., 2012). In an overall reflection of all monoracial minority themes in their entirety, a consistent pattern emerged. In an almost 'domino-effect-like' manner, these themes can be and were displayed based on both overlapping similarities and based on an actions-to-consequences-like manner within the previous results section. This begins with the presence of poor patient care, leading to the identification of the presence of racial microaggressions, resulting in increased patient mistrust in providers, linking to decreased patient confidence in providers, and the development of an increasingly unhealthy and power-imbalanced patient-physician relationship. This cycle continued to present itself throughout the discourse.

The first and second stages of this cycle, the presence of poor patient care and identification of the presence of racial microaggressions, had a significant presence within the first three thematic sections: *Facing Dismissive Attitudes from Staff, Facing Negative Attitudes/Behaviors from Staff, and Facing Racial/Cultural Stereotypes from Staff*. As displayed within the results section, these

themes best represent action-based disadvantages faced by monoracial minorities. The first theme introduced some of the most common, subtle forms of racial microaggressions experienced by patients when attempting to discuss topics regarding any perceived racism or discrimination. This then led to patients feeling as if they were not being heard and that their health challenges should be disregarded (Bond, 2022, p. 30; Tajeu et al., 2015; Punches et al., 2023). In the second theme, *Facing Negative Attitudes/Behaviors from Staff*, the issues discussed largely related to those of the previous section but differed in that the focus was shifted to negative unconscious communication. In a comparison of the two sections, both seem to highly contribute to feelings of disrespect by patients. As providers seemed less inclined to help and communicate with their patients, this then may have led to poor patient care (Bond, 2022; Hausmann et al., 2020, p. 12; Punches et al., 2023; Sue et al., 2007, p. 273; Pressbooks by University of Minnesota Libraries Publishing, 2013; Tajeu et al., 2015, p. 2079). *Facing Racial/Cultural Stereotypes from Staff* relates to both poor patient care and the identification of the presence of racial microaggressions. This theme is most similar to the day-to-day experiences within clinical settings held by monoracial minorities as the same racial microaggressions were also present. In addition, patients also felt as if providers were indirectly communicating that they should only seek treatment from those of similar racial or ethnic backgrounds, as well as attempting to construct them into identities they seemed fit/appropriate. In being subjected to such racial microaggressions, patients were exposed to poorer quality treatment/care (Bond, 2022, p. 31-35; Hausmann, 2020; Okosi, 2018, p. 99; Punches et al., 2023, p. 1197; Walls et al., 2015, p. 234).

In regard to the remaining stages of the cycle, which are marked as consequence-based, there is a significant overlap between the remaining themes as well. For example, the themes of *Facing Negative Emotional Experiences* and *Discrimination Manifests Over Time* pose as direct

consequences of the presence of the previous themes described. In presenting the first theme, it was stated that having to consistently face such a wide range of emotions when seeking clinical care leads to additional negative consequences. As described in Walls et al. (2015), undergoing such incidents presents more stress in addition to the stress initially present upon seeking healthcare and treatment. This then led to patients feeling lost and angry as it further confirmed there is no space safe from such discrimination (Bond, 2022; Okosi, 2018, p. 102-103; Punches et al., 2023; Walls et al., 2015). Such feelings directly relate to the latter theme, which is only applicable within clinical settings and acts as a long-term consequence. Constantly experiencing racial microaggressions by medical providers can potentially trigger past traumas, leading to patients then arriving armed/prepared to face any potential discrimination and/or prejudice. This then feeds into a repeating cycle of consistent re-traumatizing discrimination anytime an individual attempts to seek healthcare. Both themes then feed back into the cycle previously described, resulting in patient mistrust and decreased confidence in providers to provide proper, high-quality care (Bond, 2022, p. 31; Tajeu et al., 2015, p. 2078).

Lastly, the final theme, *Undermining Patient-Provider Relationships* best relates to the final stage of the cycle involving the development of an increasingly unhealthy and power-imbalanced patient-physician relationship. Posing as a somewhat ‘ultimate consequence’ of facing all other thematic disadvantages, this theme relates to the resulting damaged relationship between patient and provider. This includes instances where patients feel a sense of pressure to educate or censor themselves based on the microaggressions they have currently or have been exposed to in past experiences. This leaves patients stuck at a crossroads, where they feel as if they must choose between expressing their true feelings about such instances or receiving poor-quality care. Due to the presence of such negatively impactful factors, this can ultimately lead to the consequence of

the termination of treatment (Hausmann, 2020, p. 12; Okosi, 2018, p. 94-114; Punches et al., 2023, p. 1198; Walls et al., 2015).

Multiracial Themes Analysis

In a similar analysis to the previous subsection, the multiracial themes presented a noticeable connection with the descriptions listed in the literature review sections: *Racial Microaggressions: Branch to Medical Institutions and Multiracial Reality*, and *Racial Microaggressions in Medical Institutions: Multiracial Experiences*. This connection includes the identification of a significant impact of an imbalanced patient-provider power dynamic as well as the presence of the six forms of racial microaggressions against multiracial individuals within medical settings. Additionally, as this analysis was performed following that of the monoracial minority themes, several connections were made between the two as well. This will be further elaborated upon below. It should also be noted that the organization of both this and the corresponding results sections was also based on an actions-to-consequences-like manner. However, this section mainly focuses on consequential-based themes.

The first theme, *Providers Lack Experience with Patients of Mixed Race*, summarizes the disadvantage of how providers struggle or are unable to form connections to patient experiences and/or health disparities of people of color. As discussed within the results, this was associated with two potential causes: lack of understanding and lack of workforce diversity. As similarly displayed within the monoracial minority thematic results, patients felt that this has led to their health concerns not being taken seriously, resulting in lower quality care (Foster et al, 2014, p. 20; Snyder & Truitt, 2020, p. 481; Vora & Grilo, 2023, p. 8). The second theme, *Providers Dismiss/Avoid Discussing Race*, was placed as a potential consequence of the first theme.

Specifically, a poor connection with providers is commonly associated with unresponsiveness, the inability to relate to patients, and negative nonverbal communication. This consistent minimization and avoidance then led patients to feel as if providers did not want or seem to care (Foster et al., 2014, p. 15-16).

The presence of both thematic disadvantages can then lead to patients feeling less inclined to seek medical care in the future. The third theme, *Negative Impact of Avoidance of Racial Discussion*, serves as a consequential disadvantage resulting from the previously discussed themes. Similar to the fourth monoracial minority theme, *Facing Negative Emotional Experiences*, patients consistently felt a sense of pressure to either censor themselves or educate based on the behaviors or nonverbal communicative acts of their providers. This is not only disappointing to the patients in that providers fail to comfortably address such topics, but also in that providers fail to create a safe space for patients to connect with them. One distinct consequence within this theme that differs from the monoracial minority themes is that multiracial patients also expressed disappointment in that prolonged exposure to such pressures inadvertently makes it difficult to even attempt to address these topics within clinical settings (Foster et al., 2014, p. 16-21; Snyder et al., 2018, p. 234).

The fourth theme, *Presence of 6 Medical Institutional Racial Microaggressions*, best relates to the third thematic disadvantage of monoracial minorities, *Facing Unconscious Racial/Cultural Stereotypes from Staff.* As each racial microaggression was previously explained within the results, the main focus is shifted to the most prevalent microaggressions. A significant number of instances referred to *Mistaken Identity* and *Denial of Multiracial Reality* throughout the discourse. Upon closer inspection, a commonality marked present between the two microaggressions is that they are both appearance-based. Specifically, this refers to how providers perceived patients' racial

identity based on their own personal views rather than based on what the patient's own identities were, which is also a common occurrence such individuals face in their day-to-day lives (Foster et al., 2014, p. 17-20; Snyder et al., 2018, p. 232-234; Vora & Grilo, 2023). The fifth theme, *Impact of 6 Medical Institutional Racial Microaggressions*, serves as a consequential disadvantage to the previous theme. One consequence that consistently reappeared after experiencing each microaggression was patients feeling either uncomfortable or awkward, particularly due to patient confusion on how to address such situations with their providers. This theme also acts similarly to the monoracial minority theme, *Facing Negative Emotional Experiences*, as these feelings of uncertainty, discomfort, and awkwardness give further stress to the patients (Foster et al., 2014, p. 17-29; Krell et al., 2022, p. 748-749; Snyder et al., 2018, p. 235; Vora & Grilo, 2023, p. 10).

The sixth theme, *Patients Mistrust of Provider*s, serves as a greater consequential disadvantage of experiencing the previously listed themes. Similar to the *Discrimination Manifests Over Time* theme from the monoracial minority results section, this disadvantage comes with the re-traumatization of patients every time such experiences occur. This then begins an endless cycle where patients experience poor quality care, identify racial microaggressions associated with their care, increased mistrust in providers, decreased confidence in providers, and lastly a power-imbalanced patient-physician relationship where patients feel the need to come in armed/prepared to face potential racial microaggressions (Snyder et al., 2018, p. 234; Snyder & Truitt, 2020, p. 481; Vora & Grilo, 2023, p. 8; Washington-Harmon, 2024).

The final theme, *Impact on Multiracial Identity*, serves as an ultimate consequence that marks a significant difference between the monoracial minority and the multiracial thematic results. As previously described in the results section, many multiracial individuals hold a private, personal identity that does not always align with their physical appearance and may also be different from

their public identity as well (Foster, 2014). As elaborated upon within the literature review section, *Multiracial Identity: Experiences and Positionality*, the variability of self-identity for multiracial individuals largely relies upon context. This includes personal experiences of racism and discrimination, social interactions/relationships with peers and family, and the environmental racial climate of schools and communities (Jackson, 2009). Being given that every person's upbringing, lifestyle, and community are unique and feed into their own perspective, identities would therefore vary from person to person. As displayed within the literature review, multiracial identities are constantly challenged or invalidated, particularly due to the impact of factors that individuals have little to no control over such as physical appearances, geographical contexts, familial relationships, etc. (Foster, 2014). In experiencing such racial microaggressions within a clinical setting, this further contributes to the negative impact that such instances have on these individuals' lives. Both similar and different to the *Discrimination Manifests Over Time* monoracial minority theme, this consistent re-traumatization of multiracial individuals can also negatively impact the intersectional identity crisis many individuals face. This crisis differs from that of monoracial minorities (Foster et al., 2014, p. 33-34; Snyder et al., 2018; Vora & Grilo, 2023).

Monoracial Minority versus Multiracial Themes: A Comparison & Contrast

As outlined within the previous methods section, the procedure called for the analysis of both sets of themes, as well as a comparison and contrast between the two results. Any trends that appeared to have a common ground between the two separate discourse pools (multiracial versus monoracial minority) were identified and further explored through analyses to determine why and how they occurred within their circumstances in the previous section.

Some of the most common similarities identified between the two sets of results included facing negative or dismissive attitudes from staff, facing key medical institutional or day-to-day racial microaggressions, undergoing a negative impact from such experiences, and an imbalanced patient-provider relationship. Previously elaborated upon in the former subsections, it was established that many of these similarities further feeds into a re-traumatization cycle of discrimination manifesting over time, to the point where patients will then mistrust providers, expect/receive lower quality care, feel a sense of pressure to self-censor, and eventually become less inclined to seek medical treatment. Overall these results display that there is a consistent overlap in discriminatory experiences.

The results were also used to determine any key differences between the disadvantages that monoracial minorities face versus those of multiracial minorities when seeking healthcare in the United States. As also demonstrated within the former subsections, these differences include how the multiracial themes presented more consequential-based disadvantages than the monoracial minority themes, how lack of provider experience played a significant impact on the quality of care received, how a significant presence of appearance-based microaggressions took place, and how this negatively impacted the unique identity of multiracial patients. Upon further analysis of such differences, it was noted that a majority were present/derived from the multiracial theme: *Impact on Multiracial Identity*.

One of the most impactful disadvantages identified in this study was the presence of lack of provider experience with treating multiracial individuals. As demonstrated within the results/findings, this disadvantage showed to highly and negatively impact the intersectional identity crisis that is uniquely associated with multiracial individuals as this issue was not identified as a commonly recurring theme within the monoracial-minority-associated discourse

(Vora & Grilo, 2023). Furthermore, this unique microaggressive disadvantage was associated with the idealization of multiracial individuals, a second issue that was not significantly present within the monoracial-minority-associated discourse. Such messages then appear to demean monoracial identities, which in turn serves as its own racial microaggression (Foster et al., 2014, p. 34). Another key disadvantage exclusively associated with the multiracial themes comprises circumstances where patients felt caught off guard or struggled to answer/discuss questions related to racial topics when given the opportunity by providers. In a combination of the daily racial microaggressions and the re-traumatization of discriminatory experiences faced by such individuals, this issue serves as a greater and alarming consequence. Specifically, it was noted that participants from one study felt that were never 'allowed' to reflect on the extent of how being of mixed race/multiracial can impact their lives (Foster et al., 2014). Overall, the results display that were in fact disadvantages found to be exclusively associated with multiracial patients.

Results: Answering the Research Question

As previously mentioned, this procedure was used to address and answer the proposed research question and potentially support the hypothesis. The posed research question was specified as: are patients who identify as multiracial subjected to facing a unique set of racial microaggressions compared to monoracial minority patients when seeking healthcare in the U.S.?

After conducting the analysis previously described, the research question was determined to have been successfully answered. This is due to the thematic disadvantages of the multiracial discourse not only including those marked as distinctly affecting multiracial patients but also incorporating a large majority of the monoracial minority thematic disadvantages in addition to those previously mentioned. In having to undergo numerous disadvantages, this further supports

the reasoning many multiracial patients have for feeling less inclined to seek medical care in the first place.

Study Limitations

One of the most prevailing challenges in conducting this study was the issue of finding discourse that matched the criteria displayed within the previous methods section. For example, many studies that were seemingly related to the topic at hand focused on the experiences and perspectives of monoracial minority or multiracial providers in the workplace. While studying this topic is nonetheless just as important to address as the topic at hand, such findings could not be utilized in a patient-focused study. Additionally, it was also quite difficult to find qualifying discourse published closer to the present day. The original optimal range for selected discourse was set to be between the years 2018 to 2023. However, due to a lack of discourse within this field, this range was drastically expanded from 2014 to 2023. This means that a large portion of the analysis was conducted based on findings before COVID-19. To account for the modern healthcare system and current medical treatment post-COVID-19, discourse published closer to this time range would have been considered more applicable and comparable to the present day. Another noteworthy limitation would be a lack of variability of discourse within medical fields. Specifically, a majority of the selected discourse pertained to racial microaggressions within therapeutic settings. While therapy is considered a proper form of medical care/treatment as previously established, a more optimal set of discourse items would have explored this topic amongst a wide range of medical settings.

Despite these limitations, one of this study's greatest strengths lies in its internal validity. As displayed numerous times throughout the results and discussion sections, the determined thematic

disadvantages aligned with the evidence provided throughout the introduction and literature review sections. The fact that many of the same disadvantages were identified both within this study and externally further shows the prevalence of racial microaggressions and their impact on such a large demographic of people. This combined with a lack of discourse within the field further displays a need for more research within this subject area.

CONCLUSION

Once again, the overall aim of this study was to highlight key differences between the impact of racial microaggressions on multiracial patients versus monoracial minority patients when receiving healthcare, and whether identifying as multiracial places patients at a greater disadvantage within a clinical setting. A critical discourse analysis was utilized to answer the research question and test the hypothesis.

Once again, it was displayed that multiracial patients are somewhat subjected to a unique set of racial microaggressions in comparison to monoracial minority patients when seeking healthcare in the U.S. due to the consistent presence of both discriminatory overlap and exclusivity amongst the demographic. The main similarities/overlap of experiences identified between the two demographics largely focused on a continuous cycle of manifesting discriminatory experiences of facing negative and/or dismissive attitudes from staff and undergoing a negative impact from such experience that led to an imbalanced patient-provider relationship. This ultimately patients to reach a point where they mistrust providers, expect/receive lower quality care, feel a sense of pressure to self-censor, and eventually become less inclined to seek medical treatment. The main differences/exclusivity of experiences identified for that of multiracial patients in contrast to those of monoracial minorities largely centered around the negative impacts against multiracial identity, the multiracial themes presented more consequential-based disadvantages than the monoracial minority themes, how there was a lack of provider experience played a significant impact on the quality of care received, how there was a significant presence of appearance-based microaggressions took place, and how this negatively impacted the unique identity of multiracial patients.

In addition to serving as an external validation amongst the current discourse on this topic, this study can also provide practical implications for improving both monoracial minority and multiracial patient experiences. Specifically, this study can provide better insight into the provider-centered issues concerning racial microaggressions, particularly from the multiracial perspective. As research on multiracial experiences is relatively new compared to that of monoracial minorities, particularly within the healthcare system, this study may provide a better understanding/education of how providers should aim to address such topics in the future. By using studies such as this or others more oriented toward improving the education of future healthcare providers, better efforts could be made to provide training to address the presence of racial stereotypes and aim to improve imbalanced patient-provider relationships. This would include the advocation for future healthcare policies that aim to better address such issues, or even prevent them from occurring. Additionally, this study may also provide the means needed for conducting future studies on multiracial experiences within a clinical setting more comparable to the circumstances of the present day. Moreover, other potential branches of future implications for this research topic could shift the focus toward multiracial patient experiences with providers of different races. This would not only allow for better investigation and improvement of the patient-physician relationship, but to also allow for the establishment of better medical/healthcare policies to address such issues in the future.

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